Chicoine Peterson Chiropractic and Nutrition
824 Morningside Ave
Sioux City, IA 51106
712-276-9700 Fax 712-2769409

Dear Patient:

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken/ and or cancelled appointments. Please remember we have reserved appointment times especially for you. Therefore, we request at least 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute or do not show up at all, everyone loses- you, the doctor and other patients that would like to utilize your appointment time.

I, _____ hereby agree to be treated by (Dr. /Clinic) _____
For the diagnosis explained to me on _____ (Today's Date) for the condition and / or injuries that began on _____. (Date)

I hereby further agree to maintain and cooperate with the above name Doctor and/or Clinic staff recommendations for Chiropractic Care for Rehabilitation of the Spinal Condition (VSC) diagnosed from my exam or the injuries or incident sustained on _____. (Date)

In the event of excessive missed appointment without notifications or authorization to the above named Doctor or Clinic, it will be assumed that I have reached a point of stabilization and/ or symptomatic relief and that I am dismissing myself from care. Therefore, my Doctor, or Clinic can then notify my employer, insurance agent, insurance carriers, and lawyers that I am no longer being treated and I have returned to work without restrictions and or limitations.

I hereby further agree upon such notification by this office to my employer and / or attorney and /or insurance carriers, which I will pay upon demand, all bills incurred for my treatment to date.

I clearly understand this "office policy" and that all past, present and future bills incurred at this Clinic are my responsibility for payment. I hereby agree to pay all bills upon demand and my doctor will not be involved in any 3rd Party disputes. Billing for all Clinical and rehabilitation services is done as a courtesy and I understand there is no guarantee of third party payment.

Patient Signature: _____ Date_____

Parent/ Guardian Signature _____ Date _____

Doctor/ Staff Signature _____ Date _____

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HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003.

What is this all about? Specially, there are rules and restrictions on who may see or be notifies of your Health Information. These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as a patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services
We have adopted the following polices:

- Patient information will be kept confidential expect as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare provider, health laboratories, health insurance payers as is necessary and appropriate for your care.
- Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record.
- The normal course of providing care means that such records may be left, at least temporary, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff.
- You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- It is the policy of this office to remain patients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient for the practice and or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- Your confidential information will not be used for the purpose of marketing and or advertising of products, goods, or services.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal polices to conform to your request.
- You hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patients Initials _____ Parent/ Guardian Initials _____

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Medical Information Release Form (HIPAA Release Form)

Name: _____

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name of Spouse _____

Name of Children: _____ _____ _____

_____ _____ _____

Name of other member(s) _____ Relationship_____

_____ Relationship _____

_____ Relationship _____

The Release of Information will remain in effect until terminated by me in writing.

Signed _____ Date: _____

CONSENT TO X-RAY

Patient Name: _____

I hereby authorize Dr. _____ and whomever he/she designates as his/her assistant(s) to take X-rays of myself (or said minor.)

Dated this _____ day of _____, 20_____

Patient Initials _____

Parent/ Guardian Initials _____

AUTHORIZATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

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However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat any condition as he/she deems appropriate through the use of Chiropractic Health care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for the examination only and the X-ray negative will remain the property of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Signature _____ Date _____

Guardian/ Parent Signature Authorizing care _____ Date _____

PREGNANCY WARNING

I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for X-ray examination. With the full understanding of the above, and believing that I am not currently at risk, I wish to have X-ray examination performed now.

Patient Signature _____ Date_____

Guardian/ Parent Signature _____ Date _____

_____ _____ _____

Chicoine Peterson
The power that made the body heals the body
CHIROPRACTIC & NUTRITION
824 Morningside Avenue ⁂ Sioux City, Iowa 51106 ⁂ Phone: 712-276-9700 ⁂ Fax: 712-276-9409

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.

3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any overpayment exists after all insurance billing has been done, we will issue you an overpayment check - it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment is expected in full immediately; regardless of any claims submitted.

8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

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Patient Name: _____ **Date**_____ **Patient #**_____
Address: _____
City _____ **State**_____ **Zip** _____
Home Phone: _____ **Cell Phone:** _____
Work Phone: _____
Email Address: _____
Date of Birth: _____ **Social Security #** _____
Single Married Widowed Separated **Gender: Male - Female**
Occupation: _____
Have you ever had chiropractic care? Yes or No When _____
Why? _____ **Where** _____ **Were X-rays taken? Yes or no**
When was your last adjustment? _____
Date of last X-Ray?_____

How did you hear about us? _____

HEALH INSURANCE INFORMATION:
Please provide your insurance card(s) along with your driver license or photo ID. If the child is under the age of 18: we need to have a school or photo Id.
Insurance Company (Primary) _____
Insurance Phone of Primary _____

Insurance Company (Secondary) _____
Insurance Phone of (Secondary) _____

AUTO AND OTHER ACCIDENTS
Were you involved in auto accident? Yes or No When did it happen? _____
If you were involved in another accident other than auto accident—please list? _____
_____
Please describe the accident: _____
_____
_____

MAIN REASON FOR CONSULTING THE OFFICE: Circle all that apply

Become pain free	Explanation of my condition	learn how to care for my condition
Reduce symptoms	Resume Normal activity	