Sports & Spinal Injury Clinic, LLC

6634 Lake Otis Pkwy #A, Anchorage, AK 99507
Phone (907) 522-3511; Fax (907) 522-8551

Patient Name: _____
Last First Middle

Name You Prefer to be called: _____ SS#: _____

Date of Birth: _____/_____/_____ Gender: M / F Email: _____

Mailing Address/City/ST: _____ Zip: _____

□Home Phone #: _____ □Cell Phone #: _____ □Work Phone w/ext.: _____

(Please check all box(es) above where detailed messages regarding your appointment or billing issues can be left.)

Occupation: Student / Clerical / Laborer / Education / Sales / Other: _____

Employer: _____ How long?:_____

Employer's Address/City/ST: _____ Zip _____

Other Phone #'s: _____ Marital Status: Single / Married / Divorced / Widowed / Separated

Spouse's Name: _____ Spouse DOB: _____ Spouse Cell #: _____

Spouse's Employer: _____ Phone Wk #: _____

Spouse SS#: _____ Emergency Contact: _____

Emergency Contact Relation: _____ Phone #: _____

I HEARD ABOUT THIS CLINIC FROM (Name if app): _____

Payment (Circle one) **Auto • Cash/Check/CC • Health Ins • MC • Personal Injury • VA • Work Comp**

Do you have Medicare? Yes / No Is Medicare your Primary or Secondary? _____

<u>Person ultimately responsible for account</u> (If dependant is patient)

Name: _____ SS#: _____ DOB: _____

Mailing Address/City/ST: _____ Zip: _____

Home #: _____ Cell #: _____ Relationship to Patient: _____

Employer: _____ Work # _____

<u>Primary:</u>

Insured Name: _____ SS#/ID: _____ DOB: _____

Insurance Co.: _____ Group #: _____ Plan #: _____

Ins. Address/City/ST: _____ Zip: _____

Phone #: _____ Insured's Employer: _____

<u>Secondary:</u>

Insured Name: _____ SS#/ID: _____ DOB: _____

Insurance Co.: _____ Group #: _____ Plan #: _____

Ins. Address/City/ST: _____ Zip: _____

Phone #: _____ Insured's Employer: _____

I certify that I'm the patient or legal guardian listed above and consent to the collection and use of the above information to this office of chiropractic. I fully understand when the insurance company verifies my benefits <u>it is not a guarantee or authorization to pay</u> on claims submitted and that health / accident insurance policies are an arrangement between an insurance carrier and myself. I agree to pay my patient portion, plus any balance the insurance does not reimburse for, at each visit or when I receive the outstanding bill. I agree to pay/settle any denied and unpaid claims over and above insurance payments. I further understand all claims submitted by this office are my responsibility and may require my participation to settle regardless of my insurance or assignment of benefits. I also authorize the release of any information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I also understand that if my bill is not paid within 90 days of the date of service and no financial arrangements have been made, a $25 per month charge from the first month will be added to my bill. I agree that this office will file my claim form, and that Health Care Benefits or Medical Reimbursement from a Third Party Payer, if I don't have med-pay with my insurance, will be made directly to **Sports & Spinal Injury Clinic, LLC** otherwise payable to me, unless the account is previously paid in full. I understand that *<u>a discount on liens will/can be accepted only if ALL parties involved accepts the same discount and proof is available, including the **Attorneys**</u>*. I authorize **Sports & Spinal Injury Clinic, LLC** to perform any necessary diagnostic testing, ie. vital signs, range of motion, palpation, muscle strength, postural analysis, basic neurological, orthopedic testing, etc., needed during diagnosis and treatment. I understand that pain syndromes can be caused by conditions (such as tumors, etc.) which may be visualized by x-rays, however, I have decided that if the Doctor determines X-rays are not necessary for my condition that I agree also to not have x-rays and do not hold anyone associated with the **Sports & Spinal Injury Clinic, LLC** responsible for such pathology and authorize this office and its staff to examine and treat my condition as the doctors see fit. **I also understand that if I do not show for an appointment or if I give less then 12 hours notice to cancel or reschedule an appointment, that <u>I</u> am responsible for the charges of that appointment and not my insurance**. I have read and understand the included information, certify it to be true and accurate to the best of my knowledge, understand it is my responsibility to inform this office of any changes in my medical status and agree to these terms. I also agree and understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature of Patient (or Guardian) _____ Date_____

Sports & Spinal Injury Clinic, LLC

Reason For Visit Form

NAME: _____ID#: _____ DOB: _____ M / F DATE: _____

The reason for this visit is/Major complaint(s): 1._____ 2._____ 3._____ 4._____

Date each condition began? 1._____ 2. _____3. _____4. _____

What caused your condition? 1._____2. _____3. _____4. _____

When does it hurt? AM / PM #_____ Constant / Intermittent # _____ Daily / Weekly / Monthly # _____

Describe the quality/character of the pain of each complaint with its #: _____

Does it radiate to another part of your body? If so, where?: _____

Is condition getting: ❑ Worse? #_____ ❑ Better? #_____ ❑ Unchanged? #_____ ❑ Comes/goes? #_____

What helps your condition? 1._____2. _____3. _____4. _____

What aggravates your condition? 1._____2. _____3. _____4. _____

Associated Symptoms (Ex: headache, difficulty breathing, bowel/bladder dysfunction, etc.) _____

_____

Level of physical activities now from 1 to 10? (1 = Sedentary & 10 = Active) _____ Level before? _____

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine? If any, how _____

_____

Have you been treated by another Physician for **this** condition? ❑ Yes ❑ No If so, when and where?

Name of Hospital and/or Attending doctor? _____

_____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S. ❑ N.D. ❑ Other _____

How did you get there? ❑ Ambulance ❑ Private transportation Were X-rays taken? ❑ Yes ❑ No

Was medication prescribed? ❑ Yes ❑ No If so, what? _____

What's been done for this condition?: _____

_____

To evaluate the effect that continuing work will have on your recovery please complete the following: (If applicable)

Have you been able to work since this injury? ❑ Yes ❑ No # of hours in normal workday? _____

Maximum weight you are required to lift? _____

Prior to injury were you physically capable of working on an equal basis with others your age? ❑ Yes ❑ No

While in recovery, is there any light duty work you could request? ❑ Yes ❑ No ❑ N/A

Please describe your job/work: _____

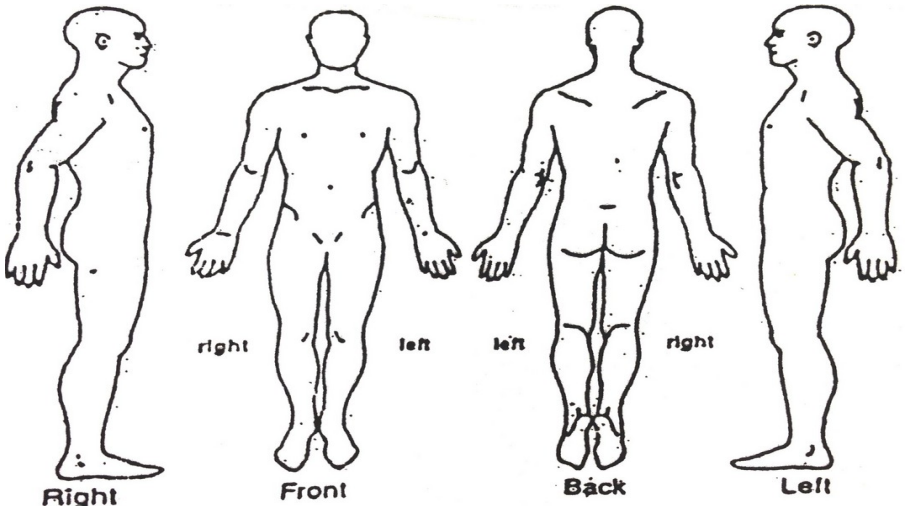
_____

Please check any of the following activities that cause pain or discomfort.

❑ Sitting / Standing	❑ Bending Forward / Backward	❑ Twisting
❑ Kneeling	❑ Pulling / Pushing / Reaching	❑ Sports
❑ Running / Walking	❑ Lying on Back / Side / Stomach	❑ Lifting
❑ Lovemaking	❑ Turning Head / Back	❑ Working

Please circle all **area(s)** of injury or discomfort and mark all areas with the appropriate symbols from below.

NN = Numbness
BB = Burning
AA = Aching
SS = Stabbing
PP = Pins & Needles
P = Pinching



Sports & Spinal Injury Clinic, LLC
Health History Form

NAME: _____ID#: _____ DOB: _____ M / F DATE: _____

Please check any of the following you have or have had.

- ❑ Alcohol / Drug Abuse
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones / Joints
- ❑ Artificial Valves
- ❑ Asthma / Difficulty Breathing
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Congenital Heart Defect
- ❑ Diabetes / Tuberculosis
- ❑ Disc Herniation _____
- ❑ Emphysema / Lung Disorder
- ❑ Fainting / Seizures / Epilepsy
- ❑ Fibromyalgia
- ❑ Frequent Neck Pain
- ❑ Frequent / Severe Headaches
- ❑ Glaucoma
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery / Pacemaker
- ❑ Hepatitis
- ❑ High / Low Blood Pressure
- ❑ HIV+ / Aids
- ❑ Kidney Problems
- ❑ Lower Back Pain
- ❑ Lupus
- ❑ Mitral Valve Prolapse
- ❑ Psychiatric Problems
- ❑ Rheumatic Fever
- ❑ Scoliosis
- ❑ Shingles
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Ulcers / Colitis
- ❑ Venereal Disease
- ❑ Other _____

Please list any medications (prescriptions and non-prescriptions) you are currently taking.: _____
_____
Please list any other serious medical condition(s) you have or ever had: _____
_____
Please list anything that you may be allergic to: _____
_____
List previous surgeries/treatments with dates: _____
_____
List any **past** serious accidents/injuries/illnesses with dates: _____
_____
List any fractures/broken bones: _____
_____
Family Health History: _____
_____
Other complaints: _____
_____
Do you smoke/chew tobacco? If so, how much? _____ How long? _____
Do you drink alcohol / drugs? If so, how much? _____ How long? _____
Do you consume caffeine on a regular basis? ❑ Yes ❑ No / How much? _____
Describe your dietary habits: _____
_____
Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports
Is your mattress supportive? ❑ Yes ❑ No Do you exercise? ❑ Rarely ❑ Frequently ❑ Routinely
Do you sleep on your ❑ Back ❑ Left side ❑ Right side ❑ Stomach
What types of exercise do you do? _____
_____
Any other relative information: _____
Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

For women: Pregnant? ❑ Yes ❑ No / How far along? _____ Nursing? ❑ Yes ❑ No
Birth Control? ❑ Yes ❑ No If so, what? _____

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INDIVIDUAL FINANCIAL POLICIES

We have prepared the following financial policy in order to help our patients determine their responsibility for payment of services rendered at our office and that you are ultimately personally responsible for all payments regardless of whether or not this office accepts insurance assignment. Please determine the statement that applies to you, initial each page letting us know that you read it, and then sign at the bottom. Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

Payment is expected at time of service unless prior arrangements have been made.

Phone Quotes

Phone quotes from your insurance company does not approve treatment nor do they guarantee payment. Any unpaid portion is your responsibility.

Health Insurance

Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

It is our policy that if you have health insurance that you believe may cover chiropractic; we will verify your insurance coverage for you. Once your eligibility and coverage are determined we will file all insurance claims for you to the extent that your policy permits, however you are ultimately responsible for payment whether your insurance pays or not. Please note, there is no guarantee of coverage as coverage and benefits are not determined until the claim is received and processed. It is against the law to write-off or to not collect your deductible, co-payment, co-insurance, any non-covered supplement, supplies or services so you are also responsible for paying any amount not covered by your insurance at the time they are rendered.

OR

If you have insurance coverage and wish to bill your own insurance instead of us, we require that you pay 100% of the services rendered at the time of each visit. We will provide you with a receipt with the necessary billing information, which you can send to your insurance carrier for reimbursement.

Non-Insured/Private Pay

We request 100% of the first visit be paid at the time of the first visit. All future visits must also be paid 100% at the time of service. If your financial situation requires special arrangements, please speak with the Billing Coordinator/Specialist.

Workers' Compensation

Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

Chiropractic services are covered by Workers' Compensation law, and you should be covered 100%, as long as your employer is aware that you were injured on the job, you have completed the required papers with your employer, your employer has no objection to your receiving care here, and you are covered by Workers' Compensation Insurance. You are responsible for non-covered items such as supplements and supports. These items are to be paid for at the time they are received. We can bill the insurance for you after you pay for them and if the insurance pays, we will reimburse you. IF YOU ARE DENIED, YOU WILL BE RESPONSIBLE FOR ALL BILLS INCURRED.

Medicare

Our Doctor is a Participating Provider with Medicare; therefore, we are required to bill Medicare for services. MEDICARE WILL ONLY PAY FOR MANIPULATION OF THE SPINE AS LONG AS IT IS NOT CONSIDERED MAINTENANCE. Medicare does require that you pay for your X-rays, examinations, supplements, physical therapy, massage and any other non-covered services at the time they are rendered unless you have a secondary insurance, NOT a supplemental insurance. You will also be required to pay an annual deductible and a small co-payment ranging from $6.50-$25.00 depending on your policy with Medicare and cannot or will not be written off. That is against the law. The amount of the deductible changes every year and we will try to inform you how much it is each year. For the year of 2020, the Medicare deductible is $198.00. If you have a true secondary insurance policy that may cover chiropractic, we can/will verify coverage and then bill them for you if Medicare does not. Please note, there is no guarantee of coverage as coverage and benefits are not determined until the claim is received and processed. Supplemental insurance will not cover anything Medicare does not, so you will be responsible for any balance Medicare will not cover. Medicare will send payment directly to our office. You will also be required to pay all visits in full once Medicare stops paying this clinic.

Massage Therapy/Rolfing

You will be required to pay in full, your co-payments at the time of service and any balance remaining your insurance does not cover.

Late Fees

If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for late fees of $25 a month going back to the first month. Please address any financial concerns to us as soon as possible.

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Automobile Accident Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

Services rendered are normally covered 100% provided there are medical payments (referred to as "med-pay") coverage on the automobile that you were in at the time of the accident. Said coverage usually has a limit of responsibility from 1 to 3 years from the date of accident, or until the available benefits are exhausted.

Should there have been another vehicle involved in the accident, and it would appear this is a liability claim, since the other party caused the accident, we would be happy to complete whatever papers are necessary to help you settle your claim. If the other vehicle that was involved was found to be liable and you would like for them to pay for your care in our office, you need to be aware that their insurance will not pay us for your visits until the claim is settled. They could also pay you directly, and most likely not pay you until the case is settled, which you would then owe us.

THEREFORE, the following is our policy regarding payment for services:

1. We will bill the insurance carrier of the vehicle you were in at the time of the accident using the "med-pay" coverage before billing the other insurance company, if it is available.
2. If no "med-pay" coverage is available on the vehicle you were in at the time of the accident or it has been exhausted we will bill your private or group health insurance if it covers chiropractic. You will be responsible for paying for your deductible, co-payments, and non-covered services at the time of service. If you have an attorney representing you in this case payment can be deferred in most cases until the case is settled.
3. If no medical benefits are available to you through med-pay or health insurance but you have an attorney representing you, we will wait for payment until the case is settled, however, we must have the attorney name, address, phone number, and we will have to verify that they are representing you. The attorney must also sign and return a lien form to this clinic within 10 days of receipt. If you are being treated on a lien basis a co-pay of $25.00 is required at each treatment. If you change attorneys, we must be informed immediately, and they must also sign and return the lien form to this clinic within 10 days of receipt and confirmed of representation.
4. If you do not have med-pay coverage, health insurance that covers chiropractic, or an attorney, you will be required to pay for all services at the time you receive them. If you require assistance in finding an attorney, please ask us. We will provide you with the name of at least 1 attorney who supports chiropractic care. If you do get an attorney, we must have confirmation from the attorney that is representing you within 10 business days of your initial visit. Payment is still expected in full at time of service until the attorney representing you has been confirmed and all lien papers are signed.

NON-VEHICULAR ACCIDENT Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

If you were involved in a non-vehicular PI case (slip or fall in a restaurant, parking lot, house, etc…) and the liability carrier has accepted liability for your injury, and agreed to pay us directly on a month to month basis, we will bill the liability insurance carrier for you.

If the liability carrier has not accepted liability or will not pay us directly, our policy regarding payment is as follows:

1. We will bill your private or group insurance if it covers chiropractic. You will be responsible for your deductible, co-payments, supplies and non-covered services at the time of service. If you have an attorney representing you in this case, payment can be deferred in most cases until the case is settled except for supplies, however, we must have their name, address, phone number, and are able to verify that they are representing you. The attorney must also sign and return a lien form to this clinic within 10 days of receipt. If you are being treated on a lien basis a co-pay of $25.00 is required at each treatment.
2. If you don't have health insurance that covers chiropractic in our office, but you have an attorney representing you, we will wait for payment until the case is settled, however we must have their name, address, phone number, and are able to verify that they are representing you. The attorney must also sign and return a lien form to this clinic within 10 days of receipt. If you are being treated on a lien basis a co-pay of $25.00 is required at each treatment.
3. If you do not have health insurance that covers chiropractic or an attorney, you will be required to pay 100% of services at the time you receive them. If you require assistance in finding an attorney, please ask us. We will provide you with the name of at least 1 attorney who supports chiropractic care. We must have their name, address, phone number, and are able to verify that they are representing you within 10 business days of your initial visit. Payment is still expected in full at time of service until the attorney representing you has been confirmed and all lien papers are signed.

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We believe this is a clear definition of our financial policy and it will allow us all to continue to concentrate on the most important issue of your health and well being.

IT MUST BE UNDERSTOOD:

1. The **privilege** of insurance assignment begins when our office receives and confirms your insurance information.
2. All deductible and/or copay payments **MUST** be made prior to insurance submittal.
3. To assist you, our office will confirm your insurance coverage to determine exactly what Chiropractic coverage is available to you under your policy. **Please note, there is no guarantee of coverage as coverage and benefits are not determined until the claim is received and processed**.
4. All deductibles, co-insurance/co-payments, non-covered supplements, or supplies are payable when service is rendered or at the end of each week with prior approval. A $300 balance must not be exceeded by any patient.
5. Since **we do not own your policy** and since from time to time, we may have difficulty in collecting from your insurance company, and the insurance assignment is a privilege, they may terminate at any time. Of course we will try to give you ample notice and ask that you act in your own behalf with **your** insurance company.
6. This office **does not** promise that an insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement or write-off any portion.
7. Should you discontinue care for any reason, other than discharge by the doctor, any and all balances due will become immediately due and payable in full by you, regardless of any claims submitted.
8. When making a health care decision it is important to remember that you, the patient, are ultimately financially responsible for any services rendered.
9. Under any circumstances, if you are denied coverage for any reason by any of the above, you will be responsible for all bills incurred.
10. If you have an attorney for your Auto/PI case, your attorney must return a signed lien to us with accepting to pay us when the case is settled within 10 days of your first visit. However, if they do not pay us for any reason, you are ultimately financially responsible. *A discount on liens will/can be accepted only if ALL parties involved accepts the same discount and proof is available, including the **Attorney**.*
11. I understand that if I want a copy of this policy, I will ask for a copy and one will be made available to me.
12. **Late Fees -** If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for late fees of $25 a month going back to the first month. Please address any financial concerns to us as soon as possible.
13. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions regarding your health care or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.
14. Due to the nature of insurance processing, I understand that I am liable for any remaining balance that the insurance does not cover. This is up to and including for the past three (3) or more years.

I have read and understand the above three (3) pages of this financial policy. I also understand that this financial policy is valid for three (3) years or until the case is settled, whichever is longer, and that I will have to re-sign another agreement if a new case is started.

SIGNATURE: _____ **PRINTED NAME:** _____
DATE: _____

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NAME: _____ID#: _____ DOB: _____ M / F DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Treatment

As part of the treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- therapeutic ultrasound
- hot/cold therapy
- massage/myofascial release
- exercise and stretches
- traction
- EMS (electronic muscle stimulation)

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle stain, cervical myelopathy, costovertebral strain and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. For comparison sake, according to the U.S. National Weather Service, the odds of being struck by lightning in your lifetime are one in 6250 and your odds in any given year for chiropractic adjustment causing a stroke is one in 750,000. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Steroid injections
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

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The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment.

_____ **Dated:** _____
Patient's Signature

_____ **Dated:** _____
Signature of Parent or Guardian
(if patient is a minor)

Please sign below after talking with the Doctor. Thank you.

I have discussed it with Dr. Matthew Huettl/Dr. David Prentice and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ **Dated:** _____
Patient's Signature

_____ **Dated:** _____
Signature of Parent or Guardian
(if patient is a minor)

_____ **Dated:** _____
Doctor's Signature