

DOCTOR/PATIENT POLICY

CONSENT TO BILL INSURANCE

I understand that Woodbeck Family Chiropractic will provide routine and reasonable insurance claims processing to most carriers as a **courtesy** for me. In return, they expect cooperation from me, if necessary; to help collect any amounts due. I understand Woodbeck Family Chiropractic reserves the right to refuse this courtesy or withdraw it at any time.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that Woodbeck Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is paid directly to Woodbeck Family Chiropractic I also understand that this amount will be credited directly to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 or outstanding balances for services I have received will be immediately due and payable.

Woodbeck Family Chiropractic's fees are considered usual, customary and reasonable by most insurance companies, and therefore are covered up to the maximum allowance determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If my insurance company has not paid a claim within sixty (60) days of submission, I agree to take an active part in the recovery of my claim. If my insurance company has not paid within ninety (90) days of submission, I accept responsibility for payment in full of any outstanding balance.

I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co-payments, or non-covered services as may be required by my insurance plan.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release Woodbeck Family Chiropractic and its employees to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services it deems necessary in my case. I furthermore authorize Woodbeck Family Chiropractic to disclose all or any part of my patient records to any person or corporation which is or may be liable under contract to Woodbeck Family Chiropractic or to me or to a family member or employer of me for all or part of the Woodbeck Family Chiropractic's charges, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the my employer. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

FINANCIAL OBLIGATION

I (the patient) agree that I am financially responsible for payment of all amounts for services provided by Woodbeck Family Chiropractic. I am responsible to pay for my services regardless of insurance coverage or other agreements between Woodbeck Family Chiropractic and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO) or Medicare, I understand that I am financially responsible for non-covered services or deductibles, co-pays or co-insurance as defined in my policy or plan. If the amount I am responsible for is not paid in full within thirty (30) days of receipt of the bill, I agree to pay interest at the legal rate as defined by Michigan statute. I further agree to pay collection costs up to 50% of the principal debt and reasonable attorney fees and expenses. I agree to waive venue. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as interest, service fees, returned check fees, court costs, and attorney fees. Credit terms are liberally awarded to active patients and strictly enforced with inactive patients.

I understand Woodbeck Family Chiropractic charges reasonable and customary fees for extraordinary processing such as reports, copies of records, etc.

Initial here: _____

It is understood and agreed that any amounts paid to Woodbeck Family Chiropractic for x-rays are for examination only. The negatives are property of Woodbeck Family Chiropractic and will remain as part of the permanent patient file.

I understand Woodbeck Family Chiropractic will not be held responsible for any pre-existing medically-diagnosed conditions.

I understand that my personal balance may not exceed \$3000 at any time and that Woodbeck Family Chiropractic may deny services until personal balance is paid in full.

TIMELY APPOINTMENTS

I understand that when I schedule an appointment that I am closing off that appointment to other potential patients. Therefore, in order for Woodbeck Family Chiropractic to provide timely service to all patients, I understand that Woodbeck Family Chiropractic requires that if I cannot make it to my appointment and have to cancel for any reason that I give a 24-hour minimum notice. I agree that I may be subject to a \$25 office visit fee, at Woodbeck Family Chiropractic's sole discretion, for *habitual* failure to provide such notice. Furthermore, I understand that third-party payers may not cover this fee.

DISCOUNTS

I understand that Woodbeck Family Chiropractic offers a Time of Service discount on all services, provided all services are paid in full when the services are rendered. For example, Woodbeck Family Chiropractic's regular price for an adjustment is \$50. If paid at the time of service, I receive a 30% discounted rate of \$35 for the adjustment. If services are not paid in full when the service is rendered, the regular price for the services performed will be billed to me, or my insurance company, if applicable. Woodbeck Family Chiropractic also offers \$360 Adjustment Cards to patients, which are good for 12 adjustments, effectively reducing the fee per adjustment to \$30.

PRIVACY

I am aware that Woodbeck Family Chiropractic publishes its privacy practices at <http://woodbeckchiropractic.com/privacy/> and I am also aware that Dr. Woodbeck will provide a hard copy of the privacy practices upon request. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc., on me by Dr. Adam Woodbeck and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

Initial here: _____

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

X _____
Printed name of Patient

X _____
Signature of Patient

Date

X _____
Signature of Legal Representative
(if patient is a minor or is handicapped)

Date

X _____
Witness to Patient's Signature

**PATIENT INFORMATION**

First name:	Middle name:	Last name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth:	SSN:
Street:	City:	
Zip code:	*Email:	
Home phone:	Cell phone:	Work phone:
Employer name:	Occupation:	
Employer street:		
Employer city:	Employer state:	Employer zip code:

SPOUSE / GUARDIAN / EMERGENCY CONTACT INFORMATION

First name:	Middle name:	Last name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth:	SSN:
Employer name:	Occupation:	
Phone:	*Email:	

During the course of care, I routinely send care plans and narrative reports to primary care physicians. It is paramount that your primary care physician have detailed knowledge of your condition and progress under my care. Please include your primary care physician's contact information below so that I may send secure, confidential reports to your doctor.

PRIMARY CARE PHYSICIAN CONTACT INFORMATION

Physician name:	Practice name:	
Street:	City:	
State:	Zip code:	Phone:

* Email is used strictly for doctor-patient correspondence or requests for more information. I will **never** sell or otherwise disclose your email address to any third party for any reason.



HEALTH HISTORY

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chorea	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Stroke
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> HIV	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Malaria	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Goiter	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Whooping cough

SOCIAL HISTORY

Marital status: Single Married Divorced Widowed

How many biological children do you have?

How many alcoholic drinks do you consume per week?

How many packs of cigarettes or other tobacco do you consume per week?

How many caffeinated beverages (e.g., coffee, pop, etc.) do you drink per week?

WORK HISTORY

Please describe your profession and any work-related stresses (i.e., prolonged sitting, standing, lifting, bending, etc.):

MEDICATIONS

Please list any medications you currently take:

SURGERIES / HOSPITALIZATIONS

Please **detail** and **date** any surgeries and hospitalizations:



BQ PRE-TREATMENT (Baseline)

This questionnaire is about the pain complaint you have presented for treatment at this clinic. We want to evaluate your treatment and therefore need to ask you now and in the future about your painful complaint and how you are doing. Please answer every question in order. The information you give will be treated in complete confidence. For **each** question, please tick **one** box only unless instructed otherwise.

- Q1 Your full name:

- Q2 Today's date:

- Q3 Age (years):

- Q4 Sex: Male Female
- Q5 What place(s) do you feel the most pain?
(more than one box allowed)
- Low back Headache
 Leg Shoulder/arm
 Neck Other
- Q6 If your pain is in your back or neck, does it go down into your leg(s) or arm(s)? Yes No
- Q7 Have you had this **same** or a similar complaint anytime in the **past**? Yes No
- Q8 Have you had a **whole month** in the past 6 months **without** any pain from a similar complaint? Yes No
- Q9 How long has this **present episode** of your painful complaint lasted?
- Less than 1 week 1 to 3 months
 1 to 4 weeks More than 3 months
- Q10 How would you describe this **present episode** of your pain?
 Comes and goes There constantly
- Q11 Has this **present episode** of your painful complaint been bad enough to limit your usual activities or change your daily routine for **more than one day**?
 Yes No
- Q12 Are you taking medication on a **daily basis**, either bought over-the-counter at a drug store or prescribed by your general practitioner, for this **present episode** of your painful complaint?
 Yes No
- Q13 Have you sought help from **any other practitioner**, such as your general practitioner or another healthcare professional, for this **present episode** of your painful complaint?
 Yes No
- Q14 How do you expect your condition to **respond to treatment** in the next few weeks?
 Recover/improve Stay about the same
 Get worse
- Q15 Are you currently in **paid employment**?
 Yes No
- Q16 Have you taken any time **off work** for this **present episode** of your painful complaint?
 Yes, 1-2 days Yes, 1-3 weeks
 Yes, 3-7 days Yes, more than 3 weeks
 Not in paid employment
 In paid employment but no taken any time off work
- Q17 Do you smoke?
 Yes No
- Q18 Compared with people of a similar age and in a similar position, how would you rate your **overall physical activity**?
 More/about the same Less
- Q19 Apart from this complaint, how would you rate your **general health and well-being**?
 Excellent Fair
 Good Poor



Mark **one** box for **each** of the following statements that best describes your painful complaint and how it is affecting you **now**. Please read each question carefully before answering.

Q20 Over the past few days, on average, how would you rate your pain on a scale where **0** is **no pain** and **10** is **worst pain possible**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q21 Over the past few days, on average, how has your complaint interfered with your daily activities (housework, washing, dressing, lifting, walking, reading, driving, climbing stairs, getting in/out of bed/chair, sleeping) on a scale where **0** is **no interference** and **10** is **completely unable to carry on with normal daily activities**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q22 Over the past few days, on average, how much has your painful complaint interfered with your normal social routine including recreational, social and family activities, on a scale where **0** is **no interference** and **10** is **completely unable to participate in any social and recreational activity**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q23 Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling, on a scale where **0** is **not at all anxious** and **10** is **extremely anxious**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q24 Over the past few days, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling, on a scale where **0** is **not at all depressed** and **10** is **extremely depressed**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q25 Over the past few days, how do you think your work (both inside the home and/or employed work) have affected your painful complaint, on a scale where **0** is **make it no worse** and **10** is **make it very much worse**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q26 Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your pain on your own, on a scale where **0** is **I can control it completely** and **10** is **I have no control whatsoever**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q27 Finally, over the past few days, how **bothersome** has your painful complaint been?

<input type="checkbox"/> Not at all	<input type="checkbox"/> Moderately	<input type="checkbox"/> Extremely
<input type="checkbox"/> Slightly	<input type="checkbox"/> Very much	

Thank you very much for your time in completing this questionnaire.