

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.

NON-COVERED MEDICARE SERVICES

Patients relying on Medicare for chiropractic coverage should be aware that Medicare does not pay for all services, regardless of medical necessity or indication. Medicare only covers chiropractic adjustments for acute conditions. It does not cover chiropractic care for maintenance (wellness) care or any of the following when ordered and/or delivered by a chiropractic physician: examinations, x-rays, physical medicine, durable medical equipment, vitamins and analgesic creams. Medicare patients will be given an Advanced Beneficiary Notice detailing non-covered services with instructions on how you'd like us to proceed.

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

Date

**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 (e.g., prolonged sitting, standing, lifting, bending, etc.):

MEDICATIONS

Please list any medications you currently take:

SURGERIES / HOSPITALIZATIONS

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

REFERRAL

Please **detail** how you learned about our practice (e.g., our website, Yellow Pages, search engine, friend/family, etc.):

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score