

ORIGINAL
BREATH
ACUPUNCTURE

Patient Contact

First Name _____ Last Name _____ M.I. _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell: _____ Carrier (for text reminders): _____
E-Mail _____

Patient Personal

Gender: Male / Female Date of Birth _____ Social Security # _____
Marital Status: Single / Married / Partnered / Other: _____
Employer Name _____ Occupation _____
Spouse Name _____ Phone _____
Who referred you to us? Name _____ Email _____

Current Injuries

Briefly describe the injury that you are coming in for in detail: _____

What is the quality of your pain? dull sharp numb tingling burning spasm other _____

Current pain level (circle one): 0 1 2 3 4 5 6 7 8 9 10

No pain

high pain

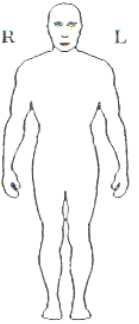
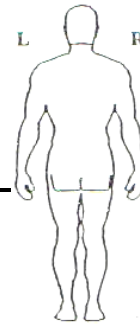
How often do you experience your symptoms? constantly daily weekly monthly yearly

How long have you been experiencing your symptoms? _____

What medications are you currently taking: _____

Primary Care Physician _____ Last Visit _____

Other _____ Last Visit _____



Assignment and release

I, the undersigning certify that I (or my dependant) have insurance coverage and assign directly to Original Breath Acupuncture all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Please mark the areas of all your complaints on the diagrams above.

Patient Signature

Date



Financial Policy

1. **(Out of Pocket)** If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care will be terminated.
2. **(Balance deferred)** If you have insurance: All deductibles or co-pays are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care will be terminated. Our payment plans make care an affordable part of your family budget.
If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility of payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you discontinue care for any reason, all balances will become due immediately regardless of any claims submitted to your insurance company.

Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me, by the licensed doctor(s) of chiropractic, medical doctor(s), licensed physical therapist(s), and/or massage therapist(s).

I further understand that there are certain degrees of risk associated with chiropractic health care and physical/massage therapy, which includes, rarely, but not limited to: fractures, disc injuries, strokes and strain/sprains, and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

(Females Patients) By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Office Policies

Our doctors have specifically created/recommended a treatment plan for you. The days they wish you to return to our office is all part of your overall care. Keeping your appointment(s) will ensure the quickest recovery possible. Since we want to ensure your recovery and allow everyone an opportunity to see the doctor in a timely manner. There is a **24 hour cancellation** policy on **massage/therapy** appointments. If an appointment is rescheduled or missed within 24 hours of your scheduled appointment time a **\$45 dollar cancellation fee for massage/therapy will be assessed** to your account. Please be advised that your insurance does not cover cancellation fees and that you are responsible for these fees. Our doctors and therapists want you to know they work hard to see you at your scheduled appointment time, however they want to make sure everyone is given adequate time for the care they need.

Notice of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining you consent. You may request restrictions on disclosures.

You may inspect and receive copies of your records within 30 days of your treatment. There may be a reasonable cost-based fee for photocopying, postage and preparation.

We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I have read the above sections of information regarding my financial obligation, consent for examination and treatment and office policies and information practices. I have had the opportunity to ask questions about my examination and treatment. By signing below, I agree to the terms and policies set forth by Original Breath Acupuncture.

Patient's name (Please Print)

Patient's Signature

Date