# JointFit, PA Chiropractic & Sports Medicine Center

**Confidential Patient Information**

3252 Kimball Ave Manhattan, KS Phone (785) 320-6868 Fax (785) 320-6861 Website: www.jointfitchiropractic.com

**Office Use Only:**
**Patient ID Number:_____**
**Dr. Richard E Foveaux DC, MS, CSCS**
**DX:_____,_____,_____,**
**_____,_____,_____**

Date:_____/_____/_____

Patient's Full Name _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children/Ages_____

Occupation:_____ Hours/Week_____ Employer:_____ Business Phone_____

Spouse's Name:_____ Employer:_____ Business Phone_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

Family Physician: _____ City: _____ State:_____ Phone_____

Payment Method: ☐ Cash ☐ Check ☐ MasterCard/Visa ☐ Insurance Do You Have Health Insurance? _____

Primary Insurance Company_____ Insured's Name_____

ID#_____ Group#_____

Secondary Insurance Company_____ Insured's Name_____

ID#_____ Group#_____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Doctor's Name _____ City: _____ State: _____

Referred By (Friend, Relative, or Physician) :_____

**Is Today's Visit Due To A Work Related Injury:** ☐ Yes ☐ No
**Is Today's Visit Due To A Personal Injury or Auto Accident:** ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)
**Date Of Injury:_____**

## AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Kansas.
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed JointFit, PA are paid in full.

Patient Signature_____ Date_____/_____/_____

**JointFit, PA Chiropractic & Sports Medicine Center** **Confidential Patient History**

**3252 Kimball Ave Manhattan, KS 66503 Phone: 785-320-6868 jointfitchiropractic@live.com www.jointfitchiropractic.com**

***Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.***

Chief complaint_____

Secondary or related complaint(s) if any:_____

Date of Onset: _____ Was the Onset ☐ Gradual ☐ Sudden Since onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT:**

Describe the quality of the complaint/pain:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ other:_____

Does any of the following make the pain worse:
- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other:_____

Describe if pain is in a single spot or does is spread out:
- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other:_____

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other:_____

How often are you aware of the pain:
- ☐ intermittent (less than 25% of time when awake)
- ☐ occasional (25-50% of time when awake)
- ☐ frequent (50-75% of time when awake)
- ☐ constant (75-100% of time when awake)

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain;_____Results:_____

What medications are you currently taking?_____

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

What is your long-term goal from treatment (e.g. play a round of golf without pain)?_____

OFFICE NOTES :_____

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In general, would you say your health is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

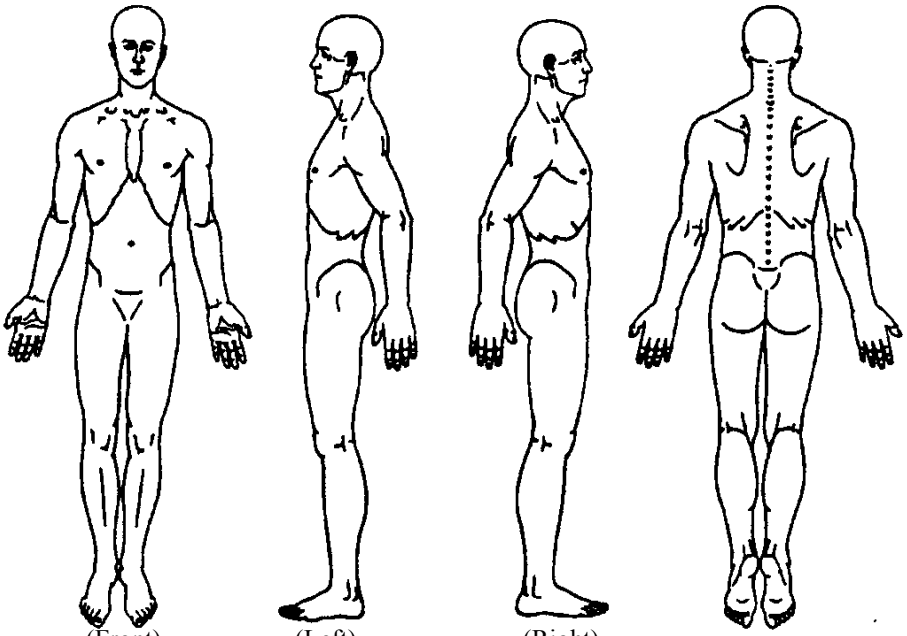
**PAST HEALTH HISTORY:**

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No If yes, When:_____
   Was treatment provided: ☐ Yes ☐ No If yes, By whom:_____ Outcome:_____
2. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: _____
3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No If yes, explain:_____
4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

| Date | Injury/Fracture/Illness/Surgeries | Treatment | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## PAIN CHART
## Please Mark Areas of Pain using these Codes!

| | |
|---|---|
| +++ | **Burning** |
| ### | **Dull/Ache** |
| *** | **Numbness/Tingling** |
| === | **Throbbing** |
| 000 | **Stabbing/Sharp** |



(Front) (Left) (Right) (Back)

## SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain.

1. Complaint:_____ 0 1 2 3 4 5 6 7 8 9 10
   no pain unbearable
2. Complaint:_____ 0 1 2 3 4 5 6 7 8 9 10
   no pain unbearable
3. Complaint:_____ 0 1 2 3 4 5 6 7 8 9 10
   no pain unbearable

# INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**TREATMENT RESULTS**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

**ALTERNATIVE TREATMENTS AVAILABLE**

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

**I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely**.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

_____Signature of Witness Date_____

# JointFit, PA Chiropractic & Sports Medicine Center
# Financial/Privacy Policy and Disclaimer

## Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

## Deductible Payments

- **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

## Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.

- If the "Explanation of Benefits" report shows the patient has an outstanding balance from services not covered by the individual insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days. After 45 days, it is the clinic's policy to turn unpaid accounts over to a collections agency unless prior arrangements have been made.**

## Returned Checks

- It is our policy to collect $35.00 for checks that are returned to us. This is to cover any fees that apply from the transaction

## Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

## Financial Policy Questions

- We are happy to address questions regarding you account at any time. Please direct accounting questions to our billing administrator, Jennifer Gilliam.

## HIPPA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you**.**

- By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

_____ _____

**patient signature** **date**

JOINTFIT.PA

CHIROPRACTIC & SPORTS MEDICINE CENTER

**Schedule of Fees**
As of 12/17/2009

| Code | Description | Amount | Type of Charge |
|---|---|---|---|
| 29280 | Taping/Bracing Hand | $5.00 | Service |
| 29540 | Taping/Bracing Foot/Ankle/Leg | $5.00 | Service |
| 97010 | Warm Moist Heat or Icing | $10.00 | Service |
| 97012 | Mechanical Traction for Neck or Back | $20.00 | Service |
| 97014 | Electrical Stimulation of Muscle/Soft Tissue | $20.00 | Service |
| 97035 | Therapeutic Ultrasound | $20.00 | Service |
| 97110 | Therapeutic Exercise (Acute P.T. care) | $35.00 | Service |
| 97112 | Neuro-muscular Re-education Training | $35.00 | Service |
| 97116 | Gait Training | $35.00 | Service |
| 97140 | Manual Therapies (Trigger point work, mobilization, myofascial release) | $35.00 | Service |
| 97504 | Orthotic/Brace Fitting | $6.00 | Regular |
| 97530 | Therapeutic Activities (Advanced dynamic P.T. to improve function) | $35.00 | Service |
| 97750 | Physical Performance Test with Written Report | $85.00 | Service |
| 98940 | Spinal Manipulation (adjustment) 1-2 Regions | $40.00 | Service |
| 98941 | Spinal Manipulation (adjustment) 3-4 Regions | $50.00 | Service |
| 98943 | Spinal Manipulation (adjustment) 5 Regions | $60.00 | Service |
| 98943 | Extremity Manipulation (adjustment) | $38.00 | Service |
| 99201 | New Patient Focused Exam | $45.00 | Service |
| 99202 | New Patient Expanded Problem Focused Exam | $60.00 | Service |
| 99203 | New Patient Detailed Exam | $80.00 | Service |
| 99204 | New Patient Comprehensive Exam/Moderate Complexity | $115.00 | Service |
| 99205 | New Patient Comprehensive Exam/High Complexity | $150.00 | Service |
| 99211 | Existing Patient Minimal Exam | $25.00 | Service |
| 99212 | Existing Patient Problem Focused Exam | $40.00 | Service |
| 99213 | Existing Patient Expanded Exam | $55.00 | Service |
| 99214 | Existing Patient Detailed Exam | $75.00 | Service |
| 99215 | Existing Patient Comprehensive Exam | $115.00 | Service |
| A9300 | Exercise Band | $5.00 | Patient |
| | Take Home Small Ice Pack | $5.00 | Patient |
| | Take Home Large Ice Pack | $6.00 | Patient |
| | Nutritional Supplements Vary By Product | | Patient |

I acknowledge that I have read and understand the fee schedule of JointFit, PA, that fees are based upon services performed, and that total visit fees may vary. I am responsible for payment for services that I receive or those that insurances may not fully cover. I understand that payment arrangements may be possible and I should inform Joint-Fit of financial difficulty prior to receiving services.

Print Name: _____ Signature: _____Date: _____

# HIPAA Notice of Privacy Practices

**JointFit, PA**
**Chiropractic & Sports Medicine Center**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**1. Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**
Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy official of your complaint. **We will not retaliate against you for filing a complaint.** You can contact our privacy official at:
**HIPAA Privacy Official**
**3252 Kimball Ave**
**Manhattan, KS 66503**

This notice was published and became effective on before **November 2, 2009.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.