

MEDPAY INFORMATION

A lot of people have medical benefits (MEDPAY) included in their automobile policies and don't even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you've been injured in an automobile accident, regardless of who is at fault. Consumers with coverage generally have between \$1,000. - \$5,000. worth of coverage.

Here are 3 reasons why we recommend that we file your Medpay.

1. **Medpay is similar to Health Insurance** – Using it does not cause your rates to increase. If your rates increase, it's most likely because:
a) It was determined that you were at fault, b) you received the police citation or ticket, or c) you've been involved in numerous reported automobile accidents within a brief period of time and therefore are now considered to be "high-risk".
2. **Filing your Medpay doesn't relieve the other party from having to pay in full for your loss.** On the contrary, by filing your Medpay, when you collect from the other driver's Liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full. If the other driver's Liability insurance refuses to make payment to you for whatever reason, filing your Medpay will help to insure that you are not stuck with all the medical bills.
3. **If you have Medpay coverage and choose not to file it, then you are paying for an option, but not receiving any benefit.**

We are not insurance experts! Please contact your insurance agent if you feel this is something you may be interested in. If after speaking to them you wish to file your Medical Payments Coverage, provide us with the claim #, adjusters name, telephone number and fax number if available. You will have to state to your insurance agent that you wish to open a claim against your Medical Payment Coverage. If you have an attorney, ask your attorney if they would like us to file your Medical Payment Coverage. If they do, follow the direction above.

Election to Not File Health Insurance Claims

To Whom It May Concern:

Upon my inquiry, the staff of Wake Forest Chiropractic has advised me that the cost of my treatment may be covered in whole or part by my own health insurance. The staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments, and these payments will be due as treatment is received. The staff has provided me with factual information regarding the various forms of reimbursement available to me and has answered my questions.

After giving due consideration to my options, I have decided that **I do not wish to file any claims on my health insurance.** I hereby instruct the staff to refrain from sending bills and treatment records to my health insurance carrier or health benefit plan. I authorize the staff to send bills and treatment records only to potential sources of payment other than my health insurance.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments. I understand that if third-party payors are billed, they will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may prevent me from filing on my health insurance at a later date. **The decision I am making today not to file on my health insurance is irrevocable.**

I understand that I remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

Today's Date is: _____

Patient

Witness

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of WAKE FOREST CHIROPRACTIC to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to WAKE FOREST CHIROPRACTIC any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to WAKE FOREST CHIROPRACTIC, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to WAKE FOREST CHIROPRACTIC for its services rendered.

I appoint WAKE FOREST CHIROPRACTIC as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with WAKE FOREST CHIROPRACTIC.

I authorize WAKE FOREST CHIROPRACTIC to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to WAKE FOREST CHIROPRACTIC for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If my balance has not been paid within 90 days after my release from care, I understand that a 1.5% monthly finance charge will be applied to my account until it is paid in full. If WAKE FOREST CHIROPRACTIC is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse WAKE FOREST CHIROPRACTIC for its costs of recovery, including reasonable attorney's fees.

Patient

Date

Witness

Notice of Lien

Pursuant to N.C.G.S.44-49 and 44-50, WAKE FOREST CHIROPRACTIC hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

WAKE FOREST CHIROPRACTIC hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S.44-50.1. WAKE FOREST CHIROPRACTIC agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

I understand as the above signed patient that if I ask to be treated under a lien and not pay for service at time of service, Wake Forest Chiropractic will not release balance statements to me as long as there is a lien in place with a liability carrier or attorney.

Wake Forest Chiropractic

By: _____

We are honored that you have chosen us for your healthcare needs and we are committed to the successful management of your condition. This will require diagnostic procedures that may include x-rays and a treatment phase that may include physiotherapy. Additionally, today's health care system requires that we reach a clear understanding to meet your needs effectively and prevent confusion.

- ✓ **We will verify your benefits, file and track your insurance payments as contracted.**
- ✓ **You are responsible for the full payment of any fees the insurance company will not cover or remain as a result of incorrect verification information received by our office.**
- ✓ **Appointments are scheduled to give optimal time and individual attention. If you need to reschedule an appointment, please give 24 hours notice. If you do not, you will impact another patient's ability to be seen during that time and may be charged a \$25 missed appointment fee.**
- ✓ **Patients that develop a pattern of missed appointments are released from care and referred to another provider who may be better suited to meet the patient's schedule and needs.**
- ✓ **For your protection, all x-rays produced in our office are sent for review by a Board Certified Chiropractic Radiologist. There is only one radiologist of this specialty in our area. The radiologist does not accept insurance assignment so there will be a nominal fee for their service.**
- ✓ **With regard to x-rays; patients or insurance companies pay for the technical service and professional interpretation of the x-rays, but do not own the films themselves. This is because physicians are required to keep the films on file for 7 years. We will be happy to mail films on 30 day loan to another physician after receipt of a records request, or we will make copies of the films (1-3 views) for \$30 for the patient's immediate use.**

INSURANCE/THIRD PARTY COVERAGE

We will supply you with information regarding deductibles, co-payments, covered charges, secondary insurance and usual and customary charges, but keep in mind that your carrier will state; "the stated benefits are not a guarantee of payment". We accept and file group health insurance, Workers' Compensation, managed care plans, Medicare, and automobile liability insurance. However, services rendered are the ultimate responsibility of the patient receiving care.

OTHER FORMS OF PAYMENT

Patients that do not have insurance or third party coverage are responsible for full payment at the time of service. We accept cash, personal checks, VISA and MasterCard. Please have any credit arrangements authorized in advance.

SPECIAL ARRANGEMENTS

We have never denied anyone the benefits of chiropractic care because of his or her inability to pay for care. If financial hardship exists, special arrangements for payment will be made.

BILLING

Some of Dr. Phelan's most gratifying days in practice are when he has provided services voluntarily during toy and food drives and in third world countries. However, if we are providing services under financial arrangements there have to be parameters. The following is a description of the management of outstanding balances that ***we would prefer never*** to follow, but do when the need arises. Please be aware of this process.

Outstanding balances are billed monthly and considered past due 30 days after the invoice date. Balances older than 90 days will accrue interest charges of 1.5% per month plus any legal or collection fees or if a credit card is required to secure care you will be notified that the credit card will be billed. Accounts may be turned over to collections after notification. Returned checks are subject to a \$25 fee.

PATIENT AGREEMENT

I have read and understood this agreement, as well as the Notice of Privacy Practices (HIPPA).

Signature of Patient/Responsible Party

Date

CONFIDENTIAL PATIENT HEALTH HISTORY

PERSONAL HISTORY

Date: _____

Name: _____ Home Phone: _____ Cell Phone: _____

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

SS#: _____ Drivers License #: _____ Date of Birth: _____ Age: _____ M F

Married Y N Height: _____ Weight: _____ lbs.

Employer: _____ Occupation: _____

Spouse/Parent: _____ Employer: _____ Work Phone: _____

Contact in case of emergency: _____ Relationship: _____ Phone: _____

Your E-mail address: _____ Number of Children: _____ Ages: _____

CURRENT HEALTH HISTORY

Describe your main complaint: _____ First noticed: _____

Has this condition happened before? Yes No When was the very first time? _____

Did something cause this to happen? Yes No If yes, please explain: _____

Is this condition related to an accident? Job related Auto Accident Sports Injury Other _____

Accident date: _____ Location of Accident: _____ Attorney name: _____

Have you seen any other doctors for this condition? Yes No Who? _____

Type of treatment: _____ Results: _____

Were x-rays taken? Yes No Where? _____ Date of x-rays: _____

Have you had previous chiropractic care? Yes No Are you able to work? Yes No

Have you missed work in the past due to this problem? Yes No If yes, when? _____

Do you suffer from any other conditions not mentioned? _____

WHAT OTHER SYMPTOMS HAVE YOU NOTICED?

General	General Continued	Eye/Ear/Nose/Throat	Cardiovascular	Other Conditions Continued
<input type="checkbox"/> Headache <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Back Pain <input type="checkbox"/> Irritability <input type="checkbox"/> Nervousness <input type="checkbox"/> Tension <input type="checkbox"/> Chest pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Head heaviness <input type="checkbox"/> Ache in arms <input type="checkbox"/> Ache in legs <input type="checkbox"/> Numbness in fingers <input type="checkbox"/> Numbness in toes <input type="checkbox"/> Short of breath <input type="checkbox"/> Fatigue <input type="checkbox"/> Depression <input type="checkbox"/> Light bothers eyes <input type="checkbox"/> Loss of memory <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Cold feet <input type="checkbox"/> Cold hands <input type="checkbox"/> Upset stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Cold sweats <input type="checkbox"/> Fever Genito-urinary <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination Gastrointestinal <input type="checkbox"/> Appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Ear ache <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> TMJ Syndrome Skin <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that won't heal <input type="checkbox"/> Hives	<input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins Other Conditions <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Breast lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors/growths <input type="checkbox"/> Ulcers	<input type="checkbox"/> Chemical dependency <input type="checkbox"/> Diabetes <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Emphysema <input type="checkbox"/> Fractures <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Hernia <input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pregnancy <input type="checkbox"/> Prostate problem <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid problem

PAST HEALTH HISTORY

Any surgeries? Yes No Any broken bones? Yes No

Describe: _____

Any Hospitalization: Yes No

Describe: _____

Medications: _____

Is there a history of bone, muscle or nerve problems in your family? Yes No

Describe: _____

Is it possible you could be pregnant? Yes No Last menstrual period: _____

Name of your Medical Doctor: _____ Phone #: _____

May we communicate our findings with your Medical Doctor? Yes No

Patient Signature: _____ **Date:** _____

Please Do Not Write Below This Line. For Office only

Chief Complaint: _____

Palliative: _____

Provocative: _____

ADL's: _____

Work: _____

Home: _____

Sports: _____

Onset: _____

Worsening? Yes No

Severity 0-10, 10 being worst: HA /10, NP /10, UBP /10, R L ARMP /10, MBP /10, LBP /10, R L LEGP /10

WAKE FOREST CHIROPRACTIC PA

PAYMENT AUTHORIZATION FORM

What is the purpose of completing this form ?

- For your security, this form allows us to store your information electronically and it is safer than swiping your Credit, Debit, FSA, or HSA cards each time you make a payment.
- It saves you time at checkout.
- You will be notified in person or by phone/message before it is processed.

Chart# _____

From Credit Card

I authorize you to charge my balance directly to one of the credit cards listed below:

Primary Card Account

(If this is a Flex Card, please provide a secondary card)

Secondary Card Account

Name on Credit Card (exactly as printed)

Name on Credit Card (exactly as printed)

Billing Address for Credit Card (Street.,Apt#)

Billing Address for Credit Card (Street.,Apt#)

City, State Zip

City, State Zip

Credit Card Number Exp. Date

Credit Card Number Exp. Date

Signature/Date

Signature/Date

Please initial below:

___ Bill all charges to the above card(s). Since the payment amount may vary, I will be notified in person or by phone/answer machine to inform me of the amount being charged and the scheduled transaction date.

___ The authorization is valid until I provide you with a written cancellation.