CAPSTONE CHIROPRACTIC CLINIC

Confidential Patient Information

Email Address _____ Today's Date: _____

Name _____ Sex ____ Marital Status ____ D.O.B _____ Age _____ Primary Phone _____

(M or F) (Mo/Day/Yr) (Area code & Number)

Address _____ City _____ State _____ Zip Code _____

(Include Street Type such as SL. Ave. etc> & Apt #)

Sec # Occupation Company Name Location Work Phone Number

Guardian/Spouse's Guardian/Spouse's D.O.B. Guardian/Spouse's Social Sec # Guardian/spouse's Employer Location Work Phone Number

Name of nearest relative (not your spouse): _____ Phone _____

Who referred you to our office? _____

Were you referred to a certain doctor in this office? _____

Is your visit due to an accident? ☐ No ☐ **Yes** (if yes, Please see receptionist for an injury report.)

YOUR PRESENT COMPLAINT _____

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

_____

List other doctor(s) see for this condition _____

Personal Medical history (if any of the following are relevant to your medical history, please check the accompanying box:)

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Digestive Disorders
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Sinus Trouble
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Upper Back Pain
☐ High Blood Pressure	☐ Epilepsy	☐ Asthma	☐ Numbness
☐ Heart Trouble	☐ Concussion	☐ Dizziness	☐ Arthritis
☐ Diabetes	☐ Hepatitis	☐ German Measles	☐ Venereal Disease

Describe any operations you've had and the dates: _____

_____

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition _____ Date of last physical exam _____

Are you now taking any medication? ☐ Yes ☐ **No** What kind? _____

Are you allergic to any medication? ☐ **Yes** ☐ No What kind ? _____

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period: _____

Do you have insurance? ☐ **Yes** ☐ No Company _____ I.D. No _____ Group No _____

Are you a Medicare Beneficiary ☐ **Yes** ☐ **No**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-insured remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Capstone Chiropractic Clinic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I also understand the any balance over 30 days past due is subject to a $10.00 late fee and interest in the amount of 1.5% each month. I hereby authorize the doctors at Conger Chiropractic Clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____

CAPSTONE REHAB, LLC

747 East South Temple, STE 200
Salt Lake City, UT 84102
801-363-2766
801-530-0413 Fax

CAPSTONECHIROPRACTIC@GMAIL.COM EMAIL

Family Medical History

Has your Mother (M), Mothers Mother (MM), Mothers Father (MF), Father (F), Fathers Mother (FM), Fathers Father (FF), Aunt (A), Uncle (U), Brother (B) or Sister (S) had any of the following issues?

Asthma	☐No ☐Yes Who?	Mental Illness	☐No ☐Yes Who?
Lung disease	☐No ☐Yes Who?	Depression	☐No ☐Yes Who?
HIV/AIDS	☐No ☐Yes Who?	Anxiety	☐No ☐Yes Who?
Heart Disease	☐No ☐Yes Who?	Suicide attempts	☐No ☐Yes Who?
Sudden cardiac death	☐No ☐Yes Who?	Cancer	☐No ☐Yes Who?
Heart Attack	☐No ☐Yes Who?	Kidney disease	☐No ☐Yes Who?
High blood pressure	☐No ☐Yes Who?	Alcohol/Drug abuse	☐No ☐Yes Who?
High cholesterol	☐No ☐Yes Who?	Hepatitis/Liver disease	☐No ☐Yes Who?
Anemia	☐No ☐Yes Who?	Neck Pain	☐No ☐Yes Who?
Stroke	☐No ☐Yes Who?	Back Pain	☐No ☐Yes Who?
Diabetes	☐No ☐Yes Who?	Disc herniation's	☐No ☐Yes Who?
Seizures	☐No ☐Yes Who?	Arthritis	☐No ☐Yes Who?

Other: (please describe) _____

_____

_____

_____

Patient signature

Conger Chiropractic Clinic
Theodore L. Conger, Chiropractic Physician
747 East South Temple, STE 200
Salt Lake City, UT 84102

ASSIGNMENT OF BENEFITS

The undersigned patient and / or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigs the physician or facility named above the following right, power and authority.

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical record, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the physician and / or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company. I, as the patient and/or responsible party further agree to cooperate, provide information as needed and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and / or facility is also assigned the exclusive, irrevocable right to request and receive from any health care or insurance company any and all information and documents pertaining to my policies including a copy of such policy, and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment or any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatments rendered by the physician/facility names above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above, following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatment for injuries are the result of the negligence of any third party, then patient(s) grant a lien against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and courts cost if incurred. Receipt of this invoiced item(s) herein and provided constitutes full and legally binding acceptance of the following payment terms: **1) PAYMENT IS DUE ON THE RECEIPT OF THE APPRAISAL 2) ACCOUNTS NOT PAID WITHIN 30 DAYS OF THE BILL DATE ARE SUBJECT TO A $10.00 MONTHLY LATE CHARGE PLUS INTEREST AT 1.5% PER MONTH ON THE UNPAID BALANCE (18% PER ANNUM),** 3) should any collection services become necessary the responsible party agrees to pay all of the cost of collection, including the agency commission of 50% and reasonable attorney fees and court costs.

STATUTE OF LIMITATIONS: Patient(s) waive the right to any statute of limitations regarding claims for services rendered or to be rendered or to be tendered by the physician/facility. I agree that nay insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or rewarded to my /our address upon request in writing to the physician/facility named above. In the event that any provision of the Agreement is determined to be invalid or unenforceable, all other provisions of the agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORAGINAL.
Signatures of patients and /or responsible party:

X_____ DATE_____

X_____ DATE_____

X_____ DATE_____

Before me this day personally appeared the person(s) whose signature(s) appears above who by me being duly sworn upon oath says(s) that the statements set forth above are true and correct. Subscribed and sworn before me this _____ day of _____ 20____.

_____Seal
Notary Public
My commission expires ____/____/_____

CAPSTONE CHIROPRACTIC CLINIC

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining the maintaining your health. We will be happy to answer all questions you may have regarding our policies, your account, or insurance coverage.

No Charge Consultation

Capstone Chiropractic Clinic will do a special : "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy

We feel the patient's health needs are paramount; therefore the following payment policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

New Patient Care Services

We require 25% of the first visit charges due on the first day of service. The balance of these charges may be made in payments over the next six weeks, unless we bill your insurance for payment.
Properly documented Work Compensation and auto accident claims are not

required to pay at this time, if appropriate forms and liens are signed.

Established Patient Care Services

Patients under care are required to make regular payments on all unpaid balances, except for properly documented Worker's Compensation or auto injury claims. Payments need to be paid monthly or semi-monthly, depending on your arrangements. We do charge (1.5%) interest & a $10.00 late fee on all accounts balances over 30 days.

You will receive a monthly statement with all of your charges itemized. Please review these and retain them for your records (taxes, etc.). We do charge for additional itemization's and the billing of additional carriers.

Our Policy On Health Insurance

Today, most health insurance policies do cover chiropractic care. We will be happy to file your primary insurance claim for you and do everything we can to assure you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover.

Appointments

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us to help others.

Emergency or After Hours Calls

In case of emergency you may contact the office for a special appointment at any time during regular office hours. If this is a life threatening emergency please call 911

Questions and Answers

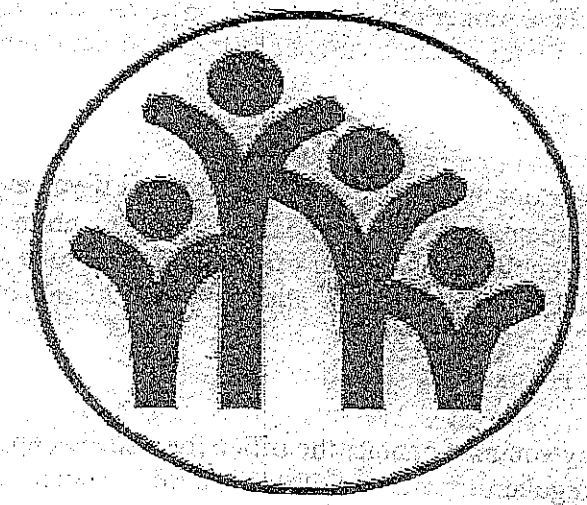
Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or available staff member. We will make every effort to answer your inquiries.

_____ _____

Patient's Signature Date

CAPSTONE CHIROPRACTIC CLINIC

OFFICE POLICY



A WISE HEALTH DECISION

IMPORTANT INSURANCE INFORMATION

Most insurance policies do cover chiropractic care. However, if yours does not, we encourage you to urge your employer or health insurance broker to change your policy to one that does. Your freedom to choose your own health care provider is a fundamental right. If we can help in any way, please let us know. Capstone Chiropractic has patient payment plan for those without health insurance.

It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, and/or their insured. Of course, Capstone Chiropractic Clinic will prepare any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, an amount authorized to be paid directly to Capstone Chiropractic Clinic will be credited to your account on receipt.

However, you must clearly understand and agree that all services rendered to you are charged directly to you that you are personally responsibility for payment. In order to facilitate the correct and rapid processing of your insurance claim, we suggest you do the following:

1- Call your insurance Company to determine exactly what coverage you have. Ask what deductible, if any, applies to your policy. Then ask how much of your claim your insurance company will pay.

2- Obtain insurance claim forms, if needed, Form your agent or insurance company, fill in the required personal information and bring them to our office. Be sure to write down all information concerning any injury (auto, work related, slipping, ext.)

3- When you bring you insurance forms to our office, please ask one of our staff to double-check them. This will help avoid unnecessary errors and give you a chance to ask any questions that you may have regarding your claim.

4- If your policy has a deductible feature, then we ask you pay this amount at the onset of your care. We also require that you keep your account current Any reimbursement form your insurance company will be promptly credited to your account.

5- Some of today's insurance policies don't provide the type of coverage that you may desire and larger patient payments will be required. If this is a hardship, ask your doctor about the Capstone Chiropractic Clinic patient payment plan. This will allow you to get the help you need.

6- If you are an auto accident or on-the-job injury victim, we suggest you discuss your coverage with our insurance office. We may have some suggestions that will help you in this regard.

7- You will be asked to authorize Capstone Chiropractic Clinic to furnish information regarding your case directly to your insurance company, and to assign all Benefits as a result of the claim. This will expedite its handling.

8- It's a good idea to know your own insurance coverage. However, if you have any question, feel free to ask. Our staff is experienced in insurance claims handling and will be glad to help in any way they can.

Conger Chiropractic Clinic
747 East South Temple, STE 200
Salt Lake City, UT 84102
801-530-4802 PH
801-530-0146 Fax

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. 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 health care providers who may be directly and indirectly involved in my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain a written Acknowledge of receipt of our Notice of Privacy Practices, but Acknowledge could not be obtains because:

- ☒ Individual refused to sign
- ☐ Communications barriers prohibited the Acknowledgment
- ☐ An emergency situation prevented us from obtain Acknowledgment
- ☒ Other (please specifiy)_____

_____

_____

Staff signature

Date