

Campbell Wellness Center

Welcome To Our Office

Patient Information

Name _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Sex: M F Marital Status: S M D W SEP
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Last Exam _____ If Minor, Parent Name _____
Patient's Nearest Relative _____ Phone _____
Employer (if minor, parent's employer) _____
Address _____ How Long Employed _____
City, State, Zip _____ Occupation _____
Referred By _____
Email Address _____

Spouse's Information

Name _____ SSN _____
Employer _____ Occupation _____
Employer's Address _____ Phone _____

Insurance Information

Primary Insurance _____
Insured _____ Policy # _____
Group # _____ Insurance Phone# _____

If accidental injury, check here and request additional forms for proper legal or insurance reporting ____.

CAMPBELL WELLNESS CENTER

PATIENT INFORMATION NECESSARY FOR INSURANCE CLAIMS FILING

Is this visit due to injuries from an accident? Y__ N__ If not, explain reason for visit:

If yes, Please explain in detail where, when, and how it happened:

Was a police report filed? Y__ N__ (If so, your insurance company will need a copy.)

Have you previously filed a medical claim form with your insurer for the current year? Y__ N__

Do you have coverage by more than one insurance company? Y__ N__ If yes, please list all insurance companies that you are enrolled in below, whether their coverage is (P) primary, (S) secondary, or (T) tertiary; the policyholder, member names for each policy; and termination date of any recently terminated policy.

INSURANCE COMPANY INSURED P S T _____
TERMINATION DATE

INSURANCE COMPANY INSURED P S T _____
TERMINATION DATE

INSURANCE COMPANY INSURED P S T _____
TERMINATION DATE

Are your spouse and/or children covered by other insurance? Y__ N__
If yes, by which insurance company? _____

Is spouse or any dependent children employed? Y__ N__
Please provide spouse's name _____
Social Security number _____ DOB _____ Employer _____

It is important that you complete all of these questions to eliminate any problems from your insurance company concerning the acceptance of your claim. Your cooperation now will hopefully eliminate future requests from your insurer for additional information, which would delay the processing of your claim. We appreciate your cooperation.

CAMPBELL WELLNESS CENTER

Appointment Policies

Dr. Campbell is dedicated to providing you with the best care possible. He will devise a treatment plan for you that will help him do exactly that. This treatment plan will include the number and frequency of visits that he projects will help you. For this reason, it is crucial that you do not miss appointments and adhere to the plan that the doctor gives you.

We understand that things can come up, and that it is not feasible to ask that you never cancel an appointment, but, keep in mind that if you must cancel, that appointment should be made up the following day.

Since Dr. Campbell is responsible for your care, it is our policy that if you miss (and do not make up) three appointments in a month, he will discontinue your care due to the inability to adhere to his treatment plan. If you are unable to follow the treatment plan, simply speak to Dr. Campbell about it, and together you can come up with something that you **are** able to follow.

Also, you will notice that when you come in, there is not a long wait time. We pride ourselves on not keeping our patients waiting for very long. In order to do this, we do ask that you schedule your appointments appropriately according to your treatment plan. Walk-ins are always welcome, though they do affect your wait time.

For these reasons, please understand that we do impose a \$25 fee for missed appointments without a 24 hour notice.

I have read and understand the appointment policies.

Patient/Guardian Signature

Date

Campbell Wellness Center

OFFICE BILLING POLICIES

Your insurance policy is a contract between you and your insurance company. We will bill all covered services to your insurance company. However, you are responsible for any deductible, co-payment, and service or items not covered by your insurance company at the time of service. Please do not ask us to bill you for these items.

We will prepare any necessary reports and forms to collect from your insurance company, and any amount authorized to be paid directly to Campbell Chiropractic Corp. will be credited to your account upon receipt. However, all services rendered to you are charged directly to you and you are personally responsible for payment of these services. If you suspend or terminate your care and treatments, fees for professional service rendered will be immediately due and payable.

We will verify benefits of your policy with your insurance company. This information is documented in our files, and will determine any deductible, co-pay, coverage of different services, etc. However, if this information is given to us incorrectly, we are not responsible for any additional monies owed to cover your account balance. THIS WILL BE YOUR RESPONSIBILITY, AS VERIFICATION OF COVERAGE DOES NOT NECESSARILY GUARANTEE PAYMENT FOR TREATMENT.

PAYMENT ON ACCOUNT

Please initial each item:

_____ We will bill all treatment dates of service once.

_____ If your insurance company requests additional information, we will submit it once.

_____ If treatment dates of service are not paid by your insurance company within 60 days of billing, you will be responsible for the complete amount owed for these services rendered. If payment is received for these charges from your insurance company, we will immediately reimburse to you any amounts paid by them.

Interest on Past Due Balances

By signing this you understand and agree that any outstanding balance over 60 days, due and payable by you shall incur interest at the annual rate of seventeen percent (17%), compounded daily, until paid in full. You also agree to be responsible for all reasonable attorney's fees and costs expended to collect said outstanding balance.

PATIENT SIGNATURE (if minor, parent signature)

DATE

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 to not 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 your physician believes it is in your best interest to permit use and disclosure of your PHI, 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 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 and accounting of certain disclosures we have made, if any, of your PHI.

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 contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

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.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name _____ Signature _____ Date _____

HIPAA Notice of Privacy Practices

_____ (name)

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.

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 healthcare 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 they 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 PHI 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, as needed, your protected health information 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: Worker's 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 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 as taken an action in reliance on the use or disclosure indicated in the authorization.