WHAT TO EXPECT AT AMOSKEAG CHIROPRACTIC INC

Visit #1 (New Patient Exam) 45 - 60 minutes

- A brief introduction to the office
- A thorough and complete biostructural examination (Completed by our Technical Chiropractic Assistant) including: digital posture analysis, thermography and digital x-rays. *
  * The Doctor will determine what is appropriate for further evaluation
- A consultation with the doctor after your completed examination to discuss health concerns.

Our office coordinator will discuss with you any fees associated with these services listed above before they are performed.

At the end of your first visit, we will schedule you for your next appointment.

Visit #2 (Review of findings/1st adjustment) 20 - 25 minutes

The Doctor will briefly discuss the results from your examination and will then review your examination findings to see where you may have Vertebral Subluxations. You will then receive a specific and gentle spinal adjustment that is specific for your condition and spine. **The normal fee for this spinal adjustment is $50.** If you have insurance, please remit your copayment. This first adjustment is important for you to experience our care and for the Doctor to see how you respond.

Visit #3 (Case Review) 60 – 90 minutes

This third visit is extremely important. The Doctor will spend 20 – 25 minutes, in a group setting, discussing their philosophy of care, as well as teach you the difference between a normal x-ray vs. an abnormal x-ray so you better understand your own x-rays when you review them individually with the doctor. Then your Doctor will be sharing their best recommendations for your case and discuss the most cost-effective and affordable way for you to benefit from corrective chiropractic care. Since you will be making a very important decision about your future health during this appointment, it is strongly recommended that you bring anyone who helps you make health and/or financial decisions with you. This ensures that if either party has questions they can discuss and voice their concerns with the doctor so everyone has a complete understanding of your particular case and recommendation for care.

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Amoskeag Chiropractic Health Questionnaire

Child's Name_____ Home Phone_____
Parent(s) Name(s) _____
Address_____ Cell Phone_____
Would you like text message reminders? Y or N If yes, Who is your wireless carrier?_____
City, State, Zip_____ Birth date_____

Male / Female Age_____ SS#_____ Email_____

Many of our patients are referred to our office by a family member or friend. Whom may we thank for referring you?_____

Why is This Form Important? As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first: to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you child has no symptoms or complaints, and is here for wellness services, please check this box ☐; others need to briefly describe the chief area of complaint, including the effect it has on the child: _____

If he/she is experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and Goes ☐ Travels ☐ Constant

Since the problem started, is it: ☐ About the same ☐ Getting Better ☐ Getting worse What makes it worse?_____

It interferes with: ☐ School ☐ Walking ☐ Sleep ☐ Sitting ☐ Hobbies ☐ Other:_____

Other doctors seen for this problem: ☐ Chiropractor_____ ☐ Medical Doctor_____ ☐ Other_____
List medications the child is taking or surgeries the child has had:_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

PREGNANCY

Where there any complications to the pregnancy?_____

Was Mom on any medications, prescription or over-the-counter? ☐ Yes ☐ No If yes, explain:_____

Did Mom or Dad smoke during pregnancy? ☐ Yes ☐ No Who?_____

Was the baby ever in the Breech position? ☐ Yes ☐ No How many ultrasounds were performed?_____

BIRTH AND DELIVERY

Where was the baby born? ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other:_____

Was the delivery: ☐ Vaginal ☐ C-section Were any devices used? ☐ Forceps ☐ Vacuum
How long was the labor?_____ How long was the delivery?_____

Was oxytocin / pitocin used? ☐Yes ☐No Was an epidural administered? ☐Yes ☐ No

INFANCY

Was the infant vaccinated? ☐Yes ☐No Was there a vaccine related reaction? ☐Yes ☐No

Was there any prolonged use of medicines or an inhaler? ☐Yes ☐No If yes, which?_____

Did the infant suffer any traumas such as a serious fall(s) or car accident(s)? ☐Yes ☐No

Has the infant been under regular chiropractic care? ☐Yes ☐No

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CHILDHOOD YEARS			
Did the child have any childhood illnesses?	☐Yes	☐No	If yes, explain:_____
Does the child play youth sports?	☐Yes	☐No	Which sport?_____
Has the child had any surgery?	☐Yes	☐No	If yes, explain:_____
Has the child fallen from a height over 3 feet?	☐Yes	☐No	If yes, explain:_____
Was the child involved in any car accidents?	☐Yes	☐No	If yes, explain:_____
Has there been any prolonged use of meds?	☐Yes	☐No	If yes, explain:_____
Has the child suffered emotional traumas?	☐Yes	☐No	If yes, explain:_____

Please give us any other health information you feel would be helpful:_____
_____

Do you have insurance? Y or N Primary Name:_____ D.O.B._____
Would you like text message appointment reminders? Y or N

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature:_____Date: _____

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Insurance Verification and Financial Policy

At Amoskeag Chiropractic Inc. we are committed to providing you and your family with the best chiropractic care possible. We are a wellness based family Chiropractic practice that encourages ongoing chiropractic care (regardless of insurance coverage) for overall health and well-being. Please understand that if you do carry insurance coverage, that there may be a portion of your Doctor recommended care that is outside the allowed standard of insurance visits and/or deemed "not medically necessary" by your insurance company. You will be expected to pay for your chiropractic care at the time the service is rendered unless you elect to participate in our Chiropractic Care Plan Agreement that include annual or monthly payments. Details of these plans will be discussed during your Report of Findings appointments.

Health Insurance: We accept and participate in many plans. Our office is happy to file insurance for you; however, it is important to know that all insurance companies state this disclaimer: **"VERIFICATION IS NOT A GURANTEE OF PAYMENT."** We verify your insurance coverage as a courtesy; this is not a guarantee of benefits. We recommend you contact your insurance company to verify your chiropractic coverage as well. It is your responsibility to thoroughly understand your insurance benefits. You are ultimately responsible for any co-payments, deductibles, and portion of care that is not covered by your health insurance. We strongly advise you to maintain contact with your insurer in order to confirm coverage and benefits. Following this procedure will help to prevent problems with billing and reimbursement.

Please verify the following information and return this form to **Amoskeag Chiropractic Inc.** at your next visit. We will also need a copy of your insurance card for our records.

INSURANCE COMPANY _____ ID#_____

Group/Plan#_____ Insurance phone #_____

Co-pay_____ Co-Insurance_____

Deductible Required?_____ Has It Been Met To Date?_____

Are X-Rays Covered?_____ Referral Needed?_____

Number Of Medically Necessary Visits Allowed_____ Per: Contract Year OR Calendar Year

Effective Date Of Insurance_____ My Plan Year Runs_____

Medicare patients – we are NOT a participating provider for Medicare, however, we will bill out to Medicare on your behalf. Medicare does not cover any examinations, X-Rays, or thermal imaging scans. These fees are the responsibility of patient at the time of service.

I, _____ have read and understand the above policies.
Print Name

Patient Signature Date

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Patient Name: _____ File: _____

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Amherst Family Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visits may be denied and this may be beyond the office's ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

Note: Our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs and disbursements of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Edward Rusher.

I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

_____

Signature (Patient, or Parent/Guardian of Patient) Date

Release of Medical Records:

I give my permission for Dr. Rusher and Dr. Pratt to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition

_____

Signature (Patient, or Parent/Guardian of Patient) Date

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name **Signature** **Date**

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature **Date**

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PRIVACY NOTICE

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

In the course of your care at **Amoskeag Chiropractic, Inc.**, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, and/or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, a HMO, a PPO, or your employer, if they are/or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminder(s), information about alternatives to your present care, inform you of health related meeting(s), workshop(s), products, and/or any other information that may be of interest to you.

If you are not home to receive an appointment reminder, a message may be left of your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your health information in our files.

PRIVACY NOTICE (CONTINUED)

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you would like further information about our privacy policies and practices please contact: Robert O. Burgett, DC or Edward J. Rusher, DC.

This office utilizes an "**open-adjusting"** environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight or one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examination or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information.

It is our desire for our staff to use your name, signature(s), video(s), photograph(s), and/or radiograph(s) on/with the following: newsletters, social media pages/accounts (including but not limited to Facebook, YouTube, etc.), emails, family picture wall, and in-office promotions. Should we desire to utilize any of your health information in this fashion, we will provide you with an additional authorization form and gather your written consent.

It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office or workshop visit.

The use of this information is intended to make your experience with our office more enjoyable as well as to further enhance your access to quality Chiropractic care.

This notice is effective as of **January 1, 2015**. This notice, and any alteration or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have read and understand the conditions of this notice.

Name (Please Print) Signature Date

If you are a minor, or if you are being represented by another party:

Personal Representative (Print) Personal Representative Signature Date

Description of the authority to act on behalf of the patient: