MAXIMUM WELLNESS REHAB

# Confidential Patient Case History

PLEASE COMPLETE THIS QUESTIONAIRE. THIS CONFIDENTIAL HISTORY WILL BE PART OF YOUR PERMANENT RECORDS.

THANK YOU.

Name:_____ DOB:___/___/____ SEX: □ M □ F

Address:_____ City:_____ Zip:_____

Soc. Sec. # _____ Home Phone: _____ Cell: _____

Work: _____ E-mail: _____

Marital Status: □ M □ S □ D □ W Children: _____Ages:_____Spouse:_____

Occupation: _____ Employer: _____

Who referred you to us?_____ How else did you hear about us? _____

What is your major complaint? _____

How long have you had this condition?_____

Have you had this or similar conditions in the past?_____

Do any positions make it feel worse?_____

Do any positions make it feel better?_____

Is this condition: □ IMPROVED □ UNCHANGED □ GETTING WORSE

Is this condition interfering with your: □ WORK □ SLEEP □ DAILY ROUTINE

OTHER:_____

Other Doctors or Therapists who have treated this condition:_____

What do you think caused this condition?_____

List any surgical operation and years: _____

Do you have a family physician? NAME:_____

Medications, Dosage and Frequency:_____

Have you been in an auto accident or had any other personal injury? _____

Describe: _____

**Maximum Wellness Rehabilitation, LLC**

The nature of Chiropractic Treatment: The doctor will use his/her hands on a mechanical device in order to move your joints. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter* analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
- *Medical Care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in a conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.
Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of Chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent.

Name (PRINTED):_____ Signature:_____ Date:_____

Witness:_____

Name (PRINTED):_____ Signature:_____ Date:_____

# HIPAA COMPLAIN AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____DOB:_____
Address:_____
Telephone:_____

I hereby authorize _____ to release my health information to:

**Maximum Wellness Rehabilitation, LLC**

The information to be disclosed to and used by the above is for the following purpose:

This authorization is limited to the following dates of treatment:

FROM: _____TO:_____

Information to be disclosed:

| | | |
|---|---|---|
| □ Emergency Room Record | □ Consultations | □ Complete Records |
| □ History & Physical Exam | □ Progress Notes | □ Abstract |
| □ Operative Reports & Pathology | □ Lab, X-rays & Tests | □ Billing Information |
| □ Discharge Summary | □ Nurses' Notes | □ X-ray Films |

Other: _____

I understand that the information to be disclose includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS AND HIV Information, as possible.

I hereby authorize the access/release/disclosure of my individually identifiable health information, as described above. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal privacy regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that this revocation will not apply to the extent that we have already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or currently with the following event or condition.

**PATIENTS SIGNATURE**:_____**DATE**:_____

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

**LEGAL REPRESENTATIVE**:_____**DATE**:_____
**RELATIONSHIP**:_____
**WITNESS**:_____**DATE**:_____

**Maximum Wellness Rehabilitation, LLC**

Binding Contract between MAXIMUM WELLNESS REHABILITATION, LLC

and patient_____.

I _____ understand that any checks made payable to me from the insurance company must be given and signed over to MAXIMUM WELLNESS REHABILITATION, LLC. The reason for this is the check that I receive is actually MAXIMUM WELLNESS REHABILITATION, LLC'S check for services rendered to me. I will not deposit this check or cash same as I understand that even of the check from the insurance company is made payable to me the rightful and legal recipient of the check is MAXIMUM WELLNESS REHIBILITATION, LLC. I understand that if I deposit or cash any checks I will be subjected to a lawsuit and severe penalties which will subject me to money damages. Any check I receive I understand that this check is for services rendered to me by MAXIMUM WELLNESS REHABILITATION, LLC. If I do not return the check I receive from the insurance company within 48 hours, I will be charged 10% interest and additional penalties. I also understand that if I do not sign the checks over to MAXIMUM WELLNESS REHABILITATION, LLC then I will be subject to a lawsuit and I will be personally responsible for attorney fees that MAXIMUM WELLNESS REHABILITATION, LLC incurs to prosecute this claim. I also understand that I could incur thousands and thousands of dollars beyond what I owe MAXIMUM WELLNESS REHABILITATION, LLC for services rendered to me if I don't sign the check over immediately. The consideration I will give in exchange for treatment is turning over the insurance company's check to MAXIMUM WELLNESS REHABILITATION, LLC when I receive it. Lastly, I understand that by signing this document I am bound by this contract.

PATIENT'S SIGNATURE: _____

DATE:_____

## Maximum Wellness Rehabilitation, LLC

### Financial / Payment Policy

Thank you for choosing MAXIMUM WELLNESS REHABILITATION, LLC for your healthcare needs. We are committed to delivering the finest service available to help you achieve your optimal health goals. Insurance and financial issues may be quite complicated in many cases. To avoid any complications that this may cause with your clinical care, we appreciate you taking the time to read our financial policies listed below. Any questions can be readily explained by our staff or administrator. When done, please sign at the bottom indicating that you understand and accept these policies.

1. **Insurance.** For the convenience of our senior patients, we presently participate in Medicare. All other insurance plan participation is variable and doctor / therapist dependent. Due to the ever changing state of insurance contracting, even though one of our physicians may have participated in a plan in the past does not guarantee that they still participate. It is your responsibility to check with this office to determine participation status. If we do not participate with your insurance plan, payment is expected at the time of service until we can verify your coverage.
2. **Co-payment and Deductibles.** All co-payments and deductibles must be paid at the time of service, or in special cases; arrangements may be made for a payment plan. For your convenience, these changes may be paid by credit card, personal check or cash. This arrangement is part of your insurance contract and failure to comply may be considered fraud. Please help us uphold the law by taking immediate responsibility for these.
3. **Proof of Insurance.** All patients are required to complete a full and accurate personal and clinical information form prior to being seen. You must also provide proof of identification (Valid Driver's License and picture ID will suffice) as well as current valid insurance information (front and back of insurance card).
4. **Claims Submission.** As stated above, after insurance verification, we will, as a courtesy, submit claims for you and work diligently to get them paid. Your insurance company may require you to submit some information directly to them. It is your responsibility to comply with their request. Even though you signed an assignment of benefits form for your insurance company, your insurance company may not honor this and check still may be delivered to you as the insured rather than to our office. If you receive and insurance checks for payment of services rendered at MAXIMUM WELLNESS REHABILITATION, LLC payment will become due immediately by you. This is simply done by bringing in the insurance check and endorsing it to MAXIMUM WELLNESS REHABILITATION, LLC within 5 business days of receiving your insurance payment. Please bring with the check a copy of the explanation of benefits (EOB) report.
5. **No Insurance.** In the case of a patient having no insurance coverage, payment is due at the time of service. However we understand that there may be special circumstances that require payment plans.
6. **Missed Appointments.** Appointments are scheduled to provide efficient and effective care. Missing appointments potentially compromises your care and final results of treatment, it is extremely important that you abide by your prescribed treatment plan in order to achieve your healthcare goals. Since appointments are scheduled by you at your convenience, we fully expect the courtesy of notice if you cannot make your scheduled appointment. It is also expected that this treatment or evaluation will be rescheduled in a timely fashion so as not to interfere with your care.

I, _____ have read, understand, and agree to the above financial policies for care at MAXIMUM WELLNESS REHABILITATION, LLC.

_____ _____

Patient or Responsible Party Signature Date

**Maximum Wellness Rehabilitation, LLC**

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## NOTICE OF PRIVACY PRACTICE

To our patients: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AS A PATIENT OF THIS PRATICE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain confidentiality of your health information.

We realize that these laws are complicated but we must provide you with the following important

information:

For the use and disclosure of your health information in certain special circumstances:

Your rights regarding your health information:

- You can request that our practice communicate with you about your health and related issues in a particular manner at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but no including psychotherapy notes. You must submit your request in writing to our office and you must pay the cost of copying.
- You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request.
- You have a right to request an accounting of disclosures of your confidential health information.
- You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy pf this notice, contact our front desk receptionist.
- You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you choose to authorize a use or disclosure, you can laer revoke it by notifying us in writing.

The following circumstances may require us to use or disclose your health information:

- To public health authorities and health oversight agencies that are authorized by law to collection information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required, to do so by law enforcement officials.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
- If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.
- To other health care providers when necessary for your treatment.
- To obtain payment for services that we provide to you, such as disclosures to claim and obtain payment from insurance companies and other payers.

This notice is effective as of _____. (DATE)

If you have any questions regarding this notice or our health information privacy policies, please don't hesitate to ask any member of our staff or contact our privacy officer at the address and telephone number listed on this notice.

I hereby acknowledge that I have been presented with a copy of MAXIMUM WELNESS

REHABILITATION'S, LLC, Privacy Practice Notice.

Patient Name (PRINTED): _____

Patient Signature: _____ Date: _____

MAXIMUM WELLNESS REHAB