First Name: ______________________________ **MI:** ________ **Last Name:** _______________________________________

Date of Birth: _________________ **Age:** ___________ **Gender at Birth:** ______________ **Gender Identified as:** ___________

Mailing Address: ____

City: ____ **State:** ________________ **ZIP:** __________________

Phone # Home: __________________________ **Cell:** ___________________________ **Work:** _______________________

Email Address: ____

SSN#: ____

Race:

☐ Declined to Provide ☐ American Indian/Alaska Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: ☐ Declined to Provide ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: ____

Interpreter required? ☐

Marital Status: ____

If married, spouse's name: ____

Patient Employer Information:

Employer: ____ **Occupation:** ____________________________________

Address: ____

Phone: ____

Spouse Employer Information:

Employer: ____ **Occupation:** ____________________________________

Address: ____

Phone: ____

Emergency Contact:

Name: ____

Address: ____

Phone #: ____

Relationship: ____

Insurance Information:

Do you have insurance? ☐ Yes ☐ No

Primary Insurance: ____

Policy Holder's Name: ______________________ **Holder's Birthdate:** ______________

Policy or Certificate #: ______________________ **Group #:** ______________

Policy Holder's Employer: ____

Secondary Insurance: ____

Policy Holder's Name: ______________________ **Holder's Birthdate:** ______________

Policy or Certificate #: ______________________ **Group #:** ______________

Policy Holder's Employer: ____

Will this case involve Workman's Comp? ☐ Yes ☐ No

Will this case involve legal action? ☐ Yes ☐ No

Date of accident, if any ______________ **Related to:** ☐ Work ☐ Auto ☐ Other

Please Note: We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement regarding a disputed claim. Payment for the office charge is expected at the time services are rendered.

Patient Signature: X ____

For New Patients Only:

We would like to thank the person(s) who referred you to us. Please take some time to fill this out as completely as possible.

How did you learn about the Ortman Clinic? (Mark with an X)

_____ **Another Patient** – Name ____

Birthdate ____

Address ____

_____ **Another Doctor** – Name ____

_____ **Website**

_____ **Facebook**

_____ **Newspaper advertisement** – which paper ______________________________

_____ **Yellow Pages**

Informed Consent To Chiropractic Treatment

Medical doctors, Chiropractic doctors, Osteopaths and Physical Therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, ultrasound, traction, laser, exercises and other therapeutic modalities may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience some muscle soreness in the first few treatments. These are likely temporary symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects or weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, our office will proceed with extra caution.

Stroke/CVA: Although strokes do happen with some frequency in our world, strokes from a chiropractic treatment are very rare. We use a non-aggressive technique for treatment and take the utmost care to prevent any type of nerve damage to our patients.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

My Signature on this consent form is good until I inform the Ortman Clinic otherwise in writing.

X________________________ X____

Date Patient Signature

__________________________ ____

Date Patient Guardian Signature (If patient is under 18 years of age.)

Thank you for choosing Ortman Chiropractic Clinic for your healthcare needs. We are committed to providing you with the best possible care. In an effort to ensure the billing process goes as smoothly as possible it is important that you understand our office policies. We are happy to discuss any questions you may have. Please keep a copy of our policies for your records.

Method of Payment

PLEASE CHECK THE APPROPRIATE BOX BELOW INDICATING YOUR METHOD OF PAYMENT.

- ☐ NON-INSURANCE (Cash/Private Pay)
- ☐ HEALTH INSURANCE
- ☐ ACCIDENT
- ☐ Other: ______________________

Ortman Chiropractic Clinic's Promise to You

- Ortman Chiropractic Clinic offers a time-of-service discount for services not covered by insurance and paid on the day of service. The following types of payment are accepted: cash, check, MasterCard, Visa and Discover Card.
- Ortman Chiropractic Clinic will file insurance claims for anyone who is **in-network** and presents an insurance card or other information needed to file a claim.
- In the event that a patient's insurance company pays more than what was originally quoted, Ortman Chiropractic Clinic will send the patient a refund check or apply the credit to the patient's account for future visits.
- Upon patient request, Ortman Chiropractic Clinic will verify insurance coverage. However, benefits quoted are not a guarantee of payment. Benefits are determined at time of claims processing.
- A copy of Ortman Chiropractic Clinic Patient Responsibility will be given to each patient.
- In addition to your treatment, other charges may apply. These include therapies, exams, supplements, orthotics, supports, etc.

Note: Any patient who fails to arrive for a scheduled appointment without notifying us is considered a "no-show". <u>We will be charging a $75 charge per occurrence after the third incident.</u>

I acknowledge that I understand and will abide by the Ortman Chiropractic Clinic Patient Responsibility policy. I am responsible for payment of all services rendered at each visit.

X____ X____________________________

Signature of Responsible Party Date

Ortman Chiropractic Clinic Patient Responsibility

INSURANCE:

- If an insurance card or other information needed is not presented at the time-of-service, patient will be a Cash/Private Pay patient. Once the insurance card or other information is presented, Ortman Chiropractic Clinic will bill your insurance from that point on.
- Patients are responsible for any portion of the bill which is left unpaid by insurance.
- Non-covered services, deductibles, co-pays, and co-insurance must be paid at the time of service.
- Medicare will only pay for adjustments to the spine. Any other treatment received will be the patient's responsibility.

ACCIDENT:

- **Patient is required to pay out of pocket the day of the appointment for all services provided.** The patient will be responsible for submitting what they paid to the accident insurance for reimbursement.

WORKERS' COMPENSATION CLAIMS:

- **Ortman Clinic will NOT treat NEW Workers' Compensation patients effective April 1, 2023.**
- However, if a workers' compensation patient is treated, the following applies:
    - Patient is responsible for giving Ortman Chiropractic Clinic the **claim number, insurance carrier, adjuster's name & phone number, and date of injury** of your case and filling out all needed data in order to file your claim. There are forms on our website or available in our office that can assist you in getting this information.
    - If the claim is denied, the patient will be responsible for payment in full.

Updating Personal Information

- It is the patient's responsibility to update their personal information file every time the personal information changes.

Additional Payment Information

- Payments must be made on a regular basis, at least one payment each month.
- Checks returned due to non-sufficient funds (NSF) will be assessed a $20.00 charge. After two NSFs, checks will no longer be accepted as a method of payment.
- Patients who have had delinquent accounts in the past may be required to pay for future visits "up-front," in cash.
- If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency (90 days past due), you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Ortman Chiropractic Clinic will work with patients in order for them to meet their financial responsibility for care and services.

Notice of Receipt of Privacy Policy
And
Appointment Reminders, Phone Calls and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (~164.524).

From time to time family or friends call to contact you while you are at the clinic for emergencies, etc. By signing below you give us authorization to tell them you are a patient and whether you are here or not.

This notice is effective as of April 16, 2003. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization. And that I have received a copy of **Ortman Clinic Privacy Policy**.

x_______________________________________
Patient Name Printed

x_______________________________
Date

x_______________________________________
Patient Signature

____
Authorized Provider Representative

____
Personal Representative Printed

____
Personal Representative Signature

____
Description of personal representative's authority to act for the patient

☐ Patient Refused to Sign