Sasseville Chiropractic
Wellness Center

Patient Information

Date: ____/____/ _____

(please circle one): Mr. Mrs. Ms. Dr. Rev. Father Sister Pastor

Full Name: _____

Address: _____

City: _____ State:_____ Zip: _____

SSN: _____-_____-_____ Gender: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Cell Company: _____

E-mail: _____

Date of Birth: ____/____/ _____ Age: _____ Emergency Contact: _____Em.#_____

Best Source of Communication: _____

How did you hear about us? _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Smoking Status: (Circle One) Current Former Never

Employers Name: _____ Occupation: _____

Work Phone: _____ Ext: _____

Primary Insurance: _____ Secondary Insurance: _____

Relationship to Insured: (Circle One) Self Spouse Child Other: _____

If self; skip to bottom of form. If spouse, child or other be sure to fill out all of the holders information.

Name of Insurance Holder: _____ Date of Birth: _____/_____/ _____

Address: _____

SSN: _____-_____-_____ Employer: _____ Phone: _____

Authorizations: I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident 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 collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Relationship: _____

Patient Case History

Name: _____ Date: _____

Please mark any allergies below:

- o Amoxicillin
- o Anesthesia
- o Animals
- o Aspirin/Pain Medicine
- o Bug Bites
- o Chlorine
- o Chocolates/Sweets
- o Codeine
- o Dairy Products (milk, cheese)
- o Dust
- o Eggs
- o Erythromycin
- o Fish
- o Gluten
- o Iodine
- o Lactose Intolerance
- o Latex
- o Morphine
- o Nuts
- o Oxycodone
- o Peanuts
- o Penicillin
- o Percocet
- o Ragweed/Pollen
- o Seasonal Allergies
- o Shellfish
- o Soaps
- o Sulfa
- o Tylenol
- o Vicodin
- o Other: _____

Please mark any surgeries below:

- o Abdomen
- o ACL
- o Adnoids removed
- o Ankle
- o Appendix
- o Back
- o Bladder
- o Brain/Tumor
- o Breast
- o Carpal Tunnel
- o Circumcision
- o C-Section
- o Ear
- o Eyes
- o Foot
- o Gall Bladder
- o Gastric Bypass
- o Heart
- o Hernia
- o Hip
- o Hysterectomy
- o Knee
- o Neck
- o Nose
- o Oral
- o Shoulder
- o Sinus
- o Spleen
- o Tonsils removed
- o Tubligation
- o Vasectomy
- o Wisdom teeth removed
- o Wrist/Hand
- o Other: _____

Please mark any past medical history conditions below:

- o Acid Reflux
- o Allergies
- o Ankle Pain
- o Anxiety
- o Arm Pain
- o Arthritis
- o Asthma
- o Back Pain
- o Bi-Polar Disorder
- o Broken Bones
- o Cancer
- o Carpal Tunnel Syndrome
- o Constipation
- o Depression
- o Diabetes
- o Difficulty Breathing
- o Dizziness
- o Ear Infections
- o Eczema
- o Elbow Pain
- o Endometriosis
- o Epilepsy
- o Eye/Vision Problems
- o Fatigue
- o Fibromyalgia
- o Foot Pain
- o Genetic Spinal Disorder
- o GERD
- o Hand Pain
- o Headaches
- o Hearing Problems
- o Heart Problems
- o Heartburn/Indigestion
- o High Blood Pressure
- o High Cholesterol
- o Hip Pain
- o Jaw Pain
- o Joint Stiffness
- o Kidney Stones
- o Knee Pain
- o Leg Pain
- o Low Back Pain
- o Lyme Disease
- o Menstrual Problems
- o Mid Back Pain
- o Multiple Sclerosis
- o Neck Pain
- o Neurological Disorder
- o Osteoarthritis
- o Osteoporosis
- o Pacemaker
- o Parkinson's Disease
- o Prostate Problems
- o Psoriasis
- o Sciatica
- o Scoliosis
- o Seizures
- o Shoulder Pain
- o Significant Weight Change
- o Spinal Cord Injury
- o Sprain/Strain
- o Stroke/Heart Attack
- o Thyroid Problems
- o Whiplash
- o Wrist Pain
- o Other:_____

Please list any medications or over the counter drugs (ie. Aspirin) you are currently taking and why:

_____
_____
_____

Please list any vitamins or supplements you are currently taking:

_____
_____

Please list any Family History Medical Conditions and Who they Relate to: (Refer to Medical Conditions Above)
Example: Mom: High Blood Pressure

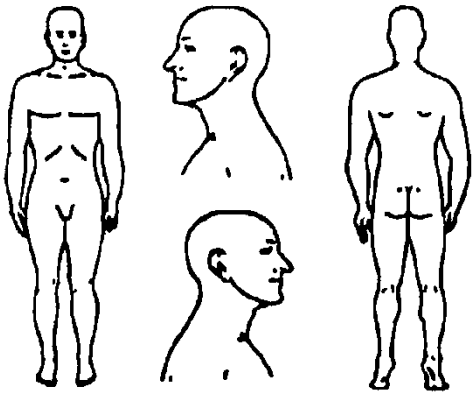
_____
_____
_____

Have you had any falls, auto or other accidents? Yes No Describe: _____

Who is your **Primary Care Physician**? _____ **Date of Last Exam**? _____
Are you pregnant? Yes No How many weeks? _____ Due Date: _____
Who is your Midwife/Obgyn? _____

Do you smoke? Yes No Packs per day? _____ Do you use other drugs/substances? Yes No
Do you drink alcohol? Yes No How many per day?_____ Do you drink caffeine? Yes No How many per day? _____
Do you Exercise? Yes No (what forms and how often?) _____

Please mark your areas of pain on the diagram below:



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your major complaint? _____Date problem began? _____
How did this problem begin (falling, lifting, etc.)? _____
Which side is the problem occurring? Right Left Both Center
Have you had this condition in the past? YES - NO
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
Is the pain: Mild Moderate Severe Unbearable
Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain
□ Tightness □ Stabbing □ Throbbing □ Other: _____
What makes your pain better (ice, heat, massage, etc)? _____
How often do you experience your symptoms?
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)
What activities aggravate your condition (working, exercise, etc)? _____

What is your SECOND complaint? _____Date problem began? _____
How did this problem begin (falling, lifting, etc.)? _____
Which side is the problem occurring? Right Left Both Center
Have you had this condition in the past? YES - NO
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
Is the pain: Mild Moderate Severe Unbearable
Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain
□ Tightness □ Stabbing □ Throbbing □ Other: _____
What makes your pain better (ice, heat, massage, etc)? _____
How often do you experience your symptoms?
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)
What activities aggravate your condition (working, exercise, etc)? _____

What is your next complaint? _____Date problem began? _____
How did this problem begin (falling, lifting, etc.)? _____
Which side is the problem occurring? Right Left Both Center
Have you had this condition in the past? YES - NO
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
Is the pain: Mild Moderate Severe Unbearable
Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain
□ Tightness □ Stabbing □ Throbbing □ Other: _____
What makes your pain better (ice, heat, massage, etc)? _____
How often do you experience your symptoms?
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)
What activities aggravate your condition (working, exercise, etc)? _____

Have you ever had chiropractic care? No Yes

When? _____Why? _____

Where? _____

Were X-rays taken? No Yes

When was your last adjustment? _____

Sasseville Chiropractic Wellness Center
416 Sabattus Street, Lewiston, ME 04240
Tel: 777-3333 Fax: 786-8921

Release Form for individuals involved in care of Patient

I, _____, give SCWC permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from SCWC. I also allow the following people to discuss information about my appointments.

This consent is valid until such time as I provide SCWC written revocation of it.

Patient Name: _____
DOB: _____

SCWC may speak with:
Name: _____ DOB: _____
Address: _____ Phone: _____
Relationship: _____

Name: _____ DOB: _____
Address: _____ Phone: _____
Relationship: _____

Name: _____ DOB: _____
Address: _____ Phone: _____
Relationship: _____

Patient/Guardian Signature: _____
Print Name: _____
Relationship to Patient: _____
Date: _____

- -

If you would like your child to be accompanied by anyone other than a parent or guardian, or to be treated alone please sign below:

I, _____, give permission for my son/daughter to be treated at Sasseville Chiropractic Wellness Center without a parent/guardian present.

_____ _____
Patient's Name Date

_____ _____
Parent/Guardian Signature Relationship to Patient

Sasseville Chiropractic
Wellness Center

416 Sabattus St.
Lewiston, Me. 04240

I,_____do not wish to receive office notes for each of my chiropractic visits.

I understand that by signing this document I am allowing Sasseville Chiropractic to omit asking if I need my office notes each time I come in.

I also understand that by signing this document that I will need to let a staff member know if I need office notes for any future visits.

_____ _____

Print Patient Name Patient's Signature

_____ _____

SCWC Representative Date

HIPAA Omnibus Notice of Privacy Practices

Revised 2018
Sasseville Chiropractic
Wellness Center
416 Sabattus St.
Lewiston, Me 04240

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 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 health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider 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, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

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, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information 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 your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.(this could be done by phone, email or mail). We use closed treatment rooms but you may still be in ear shot of other patients. Your initial and follow up evaluation notes will be sent to your Primary Care Physician.

If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death. 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 and safety as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Mainecare Benefits. In the event that Sasseville Chiropractic Wellness Center is sold or merged with another organization, your health information/records will become the property of the new owner.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. **You may revoke the authorization**, at any

time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information –This means you may ask us not to 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 your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications –You have the right to request confidential communication 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 request an amendment to 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 an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Changes to this Notice of Privacy Practices: we reserve the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that is maintains. Until such amendment is made, Sasseville Chiropractic Wellness Center is required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact us.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICER: Robyn Coleman **Phone:** 207-777-3333 **Email:** sassevillechiropractic@yahoo.com

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign below acknowledging your receipt of this notice.

_____

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

Sasseville Chiropractic
Wellness Center

Cancellation/No Show Policy

1. ***Cancellation/No Show Policy for Chiropractic Appointments***

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a $35 fee; this will not be covered by your insurance company.

2. ***Scheduled Appointments***

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We expect patients to arrive at least 5 minutes prior to their scheduled appointment.

If a patient is 10 minutes past their scheduled time, we will have to reschedule the appointment.

3. ***Cancellation/ No Show Policy for Therapy Appointments***

Due to the large block of time needed for therapy, last minute cancellations can cause problems and added expenses for the office. Typically there are patients on a wait list for these services that could have been scheduled if given appropriate advanced notice.

If therapy is not cancelled at 24 hours in advance, you will be charged a $60 fee; this will not be covered by your insurance company.

4. ***Account Balances***

We require that patients with self pay balances pay their accounts in full prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to set up a payment arrangement, may call the Billing Director to review their payment options. Patients with balances over $100 must make payment arrangements prior to scheduling future appointments.

_____ _____ _____

Patient Name Signature Date

Sasseville Chiropractic
Wellness Center

416 Sabattus St.
Lewiston, Me. 04240

Billing Policy:

Please be sure to contact your insurance company for specific benefit information. Although the chiropractor may participate with your insurance company, they may not be covered. *Some out-of-state policies do not reimburse for services provided by Doctors of Chiropractic (DC) since they do not credential them independently.*

- *We will submit your claim for you. Co-payments are due at the time of service.*
- Please direct any coverage, benefit or participation questions directly to your insurance company.
- **Be sure to give your insurance company the name of the provider you will be seeing.**

Services denied as not covered by your insurance company are your responsibility.

We appreciate timely payment on patient statements. Payment in full is due on each statement. If payment in full can not be made, please contact our billing department at 777-3333 to discuss payment options. It is important to us that we work with you to ensure continuity of care.

Patient balances are payable within 30 days of original invoicing. If the patient account balance is still outstanding after 90 days, the account will be submitted to our collection agency.

- **The patient will be responsible for any reasonable collection cost, including attorney fees if incurred.**

Who is responsible for this account? This should be the holder of the insurance plan.

May we discuss your account with the Responsible Party listed below? (Please circle one): YES NO

_____ _____ _____

Name of Responsible Party Social Security Number Relationship

_____

Address / City / State / Zip

It is your responsibility to keep us informed of any changes in your insurance coverage. Most plans have a filing limit, so any delay in the submission of claims may result in the denial of a claim. A delay caused by lack of information will be billable to you.

We accept cash, VISA, MasterCard, Discover, and personal checks. We do NOT accept American Express.

I acknowledge awareness of the billing policies of Sasseville Chiropractic Wellness Center and agree to their terms. I agree to be financially responsible for services provided to me today and in the future at Sasseville Chiropractic Wellness Center.

_____ _____

Signature of patient or responsible party Date

Non-Medicare ABN Form

Notifier: Sasseville Chiropractic Wellness Center (Chandra Sasseville DC PA)

Patient Name : _____ DOB : _____ Date : _____

Advanced Beneficiary Notice (ABN)

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

Services Below may NOT be payable by your medical plans and would need to be Paid At Time of Service

Appropriate Copays Need to be Paid at Time of Service

Items below list the estimated cost that will be billed to your insurance company. Any of these services provided that do not get paid by your insurance, will be considered **Patient Responsibility**.

Services	Estimated Cost
New Patient Exam	$175
Xrays	$60-100
Spinal Adjustments	$45-55
Extra-Spinal Adjustment	$40
Distraction	$30
Muscle Stimulation Therapies	Up to $60
KinesioTaping/Posture Rehab	$45
Muscle Trigger Point Therapy	$85-100
Acupuncture	$110-120
Re-evaluations	$65-150
Consultations	Up to $150

WHAT YOU NEED TO DO NOW

- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading
- Please draw a line through any service you DO NOT want preformed

Additional information:

If you have a managed care plan (HMO), you will need a referral from your primary care provider (PCP). Any unpaid services are your financial responsibility.

Signing below means that you have received and you understand this notice.

Signature:	Date:

416 Sabattus Street
Lewiston, ME 04240
207-777-3333

Dear Patient:

We are always happy to submit a claim to your insurance company for services rendered. However, your insurance company may not cover any service, unless you obtain a referral from your Primary Care Physician. (Please consult your member handbook regarding referrals from your Primary Care Physician)

It is your responsibility to obtain a referral. Your signature below indicates that if you receive specialty care without consent of your Primary Care Physician, you will assume financial responsibility.

Thank you.

_____

Print Name

_____

Signature Date