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: _____ Martial Status: _____

Date of Birth: _____/_____/ _____ Age: _____ Emergency Contact: _____

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

E-mail: _____

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:_____

Pediatric Information:

Birth Weight: _____ Birth Length: _____
Present Weight: _____ Present Length: _____

Was the Birth: ___ Normal Vaginal ___ Breech ___ Vacuum Extraction ___ Cesarean
___ Forceps ___ Home Birth ___ Birthing Center ___ Hospital

Pregnancy Problems: _____
Labor or Delivery Problems: _____ Apgar Scores: ____
Congenital Defects/Anomalies: _____
Was there Presence at Birth: ___ Meconium ___ Cyanosis ___ Jaundice
Pediatrician/Family MD: _____ **Date of Last Exam**: _____
Ostetrician/Mid wife: _____ **Date of Last Exam**: _____
Immunization Dates: Hep B _____ OPV _____ MMR _____
DTP _____ HIB _____ VAR _____
Childhood Diseases: Measles _____ Chicken Pox _____ Whooping Cough _____
Mumps _____ Other _____
Date and Purpose of Last MD Visit: _____

Has this child been treated for an emergency? Yes No Describe: _____

Has this child ever suffered from: (circle any that apply)

Allergies Anemia Arm Problems Arthritis Asthma Backaches
Bed Wetting Behavior Problems Broke Bones Chronic Earaches Cold/Flu
Constipation Convulsions Diabetes Diarrhea Digestion Problems Dizziness
Fainting "Growing Pains" Headaches Heart Trouble Hyperactivity
Hypertension Joint Problems Leg Problems Muscle Jerking Neck Problems Neuritis
Orthopedic Problems Paralysis Poor Appetite Rheumatic Fever Rupture/Hernias
Sinus Trouble Sugar Levels Tuberculosis Walking Problems

Diet: _____
Environmental Factors: _____

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

_____
_____
_____

Please list any <u>vitamins</u> or supplements you are currently taking:

_____
_____

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

_____
_____
_____

Is there anything else we should know about this child? _____

What is the **major complaint**? _____Date problem began? _____
How did this problem begin (falling, lifting, etc.)? _____
How is the condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING
Has this condition exsisted in the past? YES - NO

How often does he/she experience the 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)

Describe the nature of the symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain
□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate the 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

How do the symptoms affect their ability to perform daily activities?
(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate the condition (working, exercise, etc)? _____
What makes the pain better (ice, heat, massage, 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
Dr. Chandra Sasseville and Dr. Ted Stratman
416 Sabattus Street, Lewiston, ME 04240
Tel: 777-3333 Fax: 786-8921

Sasseville Chiropractic Wellness Center

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: _____

HIPAA Omnibus Notice of Privacy Practices

Revised 2014
Sasseville Chiropractic Wellness Center
Dr. Chandra Sasseville & Dr. Ted Stratman
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. 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 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, 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.

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.

(Continued on next page)

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.

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 the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Sasseville Chiropractic Wellness Center

Dr. Chandra L. Sasseville
Dr. Ted Stratman
416 Sabattus St.
Lewiston, Me. 04240

Privacy Notice:

Along with the new HIPAA regulations, we have other policies which are mandated to protect your privacy. Please be assured that your records are strictly confidential. Your records are only sent to Insurance Companies, other than your own, with a signed release from you.

We are asking for permission, required by HIPAA, to send your initial and follow up evaluation notes to your Primary Care Physician. We would also like to send you Birthday Cards, Appointment Reminder Cards, Recall Cards, Sympathy Cards and Referral Thank You Card. Also, we are asking your permission to make phone calls to you as needed, at the phone numbers you have provided to us, and to leave a message when appropriate. In our office, we use sign in sheets on the front desk and would like your signature on them at every visit. We also use close treatment rooms where you may be in ear shoot of another patient. Please submit your e-mail address below for newsletters, information sheets, credit card receipts and other documents SCWC needs to e-mail to you.

We understand that at any time you have the right to revoke such authorization by issuing a written request to Sasseville Chiropractic Wellness Center.

We are required by HIPAA laws to have your signature on file annually, giving us permission to perform the above mentioned tasks.

Yours in Health,

Dr. Chandra L. Sasseville, Dr. Ted R. Stratman and staff

By my signature below, I give permission to Dr. Sasseville, Dr. Stratman and their staff to use my patient information in the manner described in this letter and the new HIPPAA letter.

_____ _____

Print Name Signature

_____ _____

Email Address Date

Sasseville
Chiropractic
Wellness Center

Dr. Chandra L. Sasseville
Dr. Ted Stratman
416 Sabattus St.
Lewiston, Me. 04240

Our office is very grateful for the support and loyalty which our patients show our practice. In fairness to all of you, we would like to clarify our office policy regarding missed appointments, arriving 15 minutes late for an appointment, and last minute cancellations. We are aware of the wait many of you have to experience before you can have your treatment needs met, so in an effort to best meet these needs, we are implementing a guideline to address these troublesome occurrences. When a patient does not honor their appointment they are adversely affecting three parties: first and foremost they are putting their health at risk by not addressing their own chiropractic needs. Secondly, they are creating a void in the schedule that Dr. Sasseville and her staff could be utilizing to treat other patients in need of chiropractic care. Finally, they are showing a discourtesy to other patients in the practice who have had to wait for their appointments.

With these points in mind, we are implementing the following policy effective immediately. One missed appointment or cancellation without at least 24 hours notice **may** result in a charge of at least $35.00 at the staff's discretion. If there are two or more broken or late cancellation of an appointment there **will** be a **minimum** $50.00 charge per occurrence. If a patient shows up more than 15 minutes late for an appointment, this **may** be considered a no show and will need to be rescheduled. We apologize for any occasions where you may have to wait, but these are almost always a result of an emergency treatment of one of our patients or an unforeseen treatment need on a scheduled patient. It is **not** because we deliberately overbooked our schedule.

As a courtesy of our office, we have implemented a system via text and e-mail reminders for scheduled appointments. However, as there may be technology glitches, patients are still held responsible for their appointments and the missed appointment policy will be enforced.

Since most of our patients are considerate of both their chiropractic needs and respectful of our time, the aforementioned plan will not have any affect. However, for those who have continued to compromise appointment availability for other patients, these guidelines will be strictly enforced. Once again, we thank you for your trust and confidence and look forward to providing you with the highest quality of chiropractic care.

Dr. Chandra L. Sasseville, Dr. Ted Stratman and Staff

Sasseville Chiropractic Wellness Center

_____ _____

New Patient Signature **Date**

Sasseville
Chiropractic
Wellness Center

Dr. Chandra L. Sasseville
Dr. Ted Stratman
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