Winston Chiropractic Care, P.C.
11175 Ridgefield Parkway, Suite 103 Richmond, Va 23233
WELCOME TO OUR OFFICE! PLEASE COMPLETE ALL QUESTIONS.

NAME:		DATE:
ADDRESS:		CITY/STATE/ZIP:
HOME PHONE:	WORK:	CELL:
DATE OF BIRTH:	AGE:	SOCIAL SECURITY:
MARITAL STATUS: M W D S		
OCCUPATION:		EMPLOYER:
SPOUSE'S NAME:		SPOUSE'S EMPLOYER:
CHILDREN'S NAMES AND AGES:		
FAVORITE HOBBIES OR INTERESTS:		
METHOD OF PAYMENT FOR FIRST VISIT: CASH CHECK CREDIT CARD		

Current health complaints/ reasons for consulting our office:
1. _____
2. _____
3. _____
4. _____

Indicate any function below that aggravate or are aggravated by your condition: (circle all that apply)

WALKING STEP CLIMBING DRIVING WORKING RECREATION VISION BREATHING

DIGESTION SINUSES HEARING SMELLING SLEEPING BOWEL MOVEMENTS MENSTRUAL

Who may we thank for referring you?_____
Have you had same or similar problem(s) before? _____
If so, for how long? _____
Is this the result of an auto or work injury? _____If so, when?_____
_____
Father, mother, brother, sister, children with similar problems?_____
If so, who?_____
Other doctors you have seen for this problem: _____
Surgeries you have had:_____
_____
Medications you currently take:_____

FLIP OVER

Is there any chance you are pregnant? _____
Have you ever been diagnosed with cancer?_____
If so, what kind?_____
Do you have health insurance? _____
Name of company:_____
Would you like our bi-monthly e-mail newsletter?:_____
E-mail address_____

The above information is true and accurate to the best of my knowledge. Patient or Guardian Signature: Date:

1.All first visit charges are payable when services are rendered.
2.The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Winston Chiropractic Care 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 Winston Chiropractic Care will be credited to my account upon receipt. **However**, I clearly understand and agree that I am personally responsible for payment.

_____ _____
Patients Signature Date

_____ _____
Guardian's signature authorizing care for minor Date

In case of EMERGENCY, please notify:_____
Relationship to you:_____
Address:_____
Phone: _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify 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-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
(signature) (date)

Payment Policies and Insurance Information

Patient Name: _____ Date: _____

Insurance Company:

Effective Date:

Copay/Coinsurance:

Deductible:

Yearly Maximum:

Services not covered:

All payments are expected at the time of service. We do accept master card, visa, debit card, checks or cash for your convenience. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Rates are subject to change at any time. You are ultimately responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Patients with insurance- It is our policy to verify your insurance coverage on or before your first visit to avoid misunderstandings. If you do not have your insurance information and a driver's license on your first visit you will be responsible for paying the cash rate for services at the time services are rendered. Due to changes in the insurance industry it is no longer an easy task to interpret each patient's individual policy. We try to stay aware of changes but it is not always possible. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you being responsible for any charges unpaid by your insurance company. There is no guarantee by any insurance company to make payment on any claim. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will not enter into any dispute with your insurance company concerning reimbursement or the amount your insurance company covers. THE BILL IS ULTIMATELY YOURS TO PAY.

Personal injury patients- Patients involved in auto accidents may receive coverage for treatment under the medical payment portion of their auto policy and/or health insurance. Regardless of who is the responsible party, a claim will be established with your car insurance company. We required a copy of your medical insurance coverage card, driver's license, auto insurance card and the other person involved in the accident should their insurance be responsible. You will be required to pay your copay(insured patients) or the cash rate(uninsured patients) at the time of service. PLEASE UNDERSTAND THAT YOU ARE PERSONALLY RESOPNSIBLE FOR THE BILL. Our office cannot defer payment until the attorney or car insurance wants to pay.

Patients without insurance- All payments are expected at the time of service.

By signing below you acknowledge that you have read and understand this information and that you have been informed of current rates.

Patient Signature: _____ Date: _____

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.

Dr. Winston , D.C. is required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as describe in this notice.

How Dr. Winston May Use or Disclose Your Health Information

Dr. Winston protects the privacy of your health information. The law permits Dr. Winston to use or disclose your health information for the following purposes.

- Treatment, Payment, and Regular Health Care Operations- Information obtained by Dr. Winston will be used to dispense and provide prescription ophthalmic goods and services to you, bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- As and When Required by law- We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.) Judicial and Administrative, Deceased Person Information, Worker Compensations programs, Food and Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
- Personal Communications – We may contact you to provide appointment reminders, and other information about treatment alternatives or other health –related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
- Victims of Abuse, Neglect, or Domestic Violence- We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect , or domestic violence.

Marketing Communications: We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatments, or providers without authorization.

When Dr. Winston May Not Use or Disclose Your Health Information: Except as described in this notice of Privacy Practices, Dr. Winston will not use or disclose your health information without your written authorization. If you do authorize Dr. Winston to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosers, we must follow your state law.

You have the following rights with respect to your health information:

- You have the right to request restrictions on certain uses and disclosures of your health information. To make such a request, you must complete the Restriction of the Use of Patient Information form and the request will apply only to the location providing services. Dr. Winston is not required to agree to the restriction that you requested.
- You have the right to inspect and copy you health information as long as Dr. Winston maintains the health information. Your health information usually will include prescription and billing records. To inspect or copy your health information, you must complete a Request to Inspect Medical Records form and submit the request to the location that provided your services. We may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- You have the right to request that Dr. Winston amend your health information that is incorrect and incomplete. To request an amendment, you must complete a Request to Amend Medical Records to the location providing services. Dr. Winston is not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.
- You have the right to receive and accounting of disclosures of your health information we have made after April 14, 2003 for most purposes other than treatment, payment, health care operations, information provided to you, and certain government functions. To request and accounting, you must complete a Request for Accounting of Disclosure to the location providing services. You must specify the time period but it may not be longer than six years. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time.
- You may request communication of your health information by alternative means or at alternative locations. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must complete a Request for Alternative Communication to the location providing services. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

If you would like to exercise one or more of these rights, contact the location that provided you services or submit a written request to Dr. Winston, HIPAA Coordinator, 11175 Ridgefield Parkway, Richmond, VA 23233

Changes to this Notice of Privacy Practices

Dr. Winston reserves the right to amend our practices and this Notice of Privacy Practices at any time in the future and make the new Notice effective for all medical information we maintain. Until such amendment is made, Dr. Winston is required by law to comply with this Notice. The revised notice will be posted in the office and a paper copy will be available upon request.

For more information or to report a problem

If you have questions or would like additional information about Dr. Winston's privacy practices, you may contact Dr. Winston at the address above. If you believe your privacy rights have been violated, you may file a written complaint using our HIPAA Complaint form, to the address above, or with the Secretary of Health and Human Services.

PLEASE SIGN ON BACK→

HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I,_____(please print full name), have been presented with the Notice of Privacy Policy of Dr. Winston D.C. and have been offered a copy of such policy to keep for my records.

_____(please initial here) I hereby acknowledge that I have been provided with a copy of the policy

_____(please initial here) I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide treatment to me.

_____
Signature of Patient / Guardian Date

FOR OFFICE USE ONLY

I, _____(please print full name) acting as
_____(please print position in office) for Dr. Winston D.C., attempted to obtain the written acknowledgement of receipt of the Policy of Provider on _____(please print date attempt was made), but acknowledgement could not be obtained because:

_____(initial here) Patient or Patients Legal rep. Refused to sign.

_____(initial here) Patient or Patient's legal rep. Could not be communicated with sufficiently to obtain acknowledgement.

_____(initial here) Emergency circumstances prevented securing acknowledgement.

_____(initial here) Other (please specify)
_____
_____
_____
_____
_____