

Parliament Chiropractic, LLC

David W. Parliament, DC

Ryan S. Fordt, DC

2665 E. Tudor Rd, Suite 201

Anchorage, AK 99507

Phone: (907)222-5100 Fax: (907) 222-5412

www.ParliamentChiropractic.com

Date: _____

Patient Demographics

Name: _____ **Date of Birth:** _____ **Age:** _____
(last) (first) (Initial)

Home Phone: _____ Cell Phone: _____

E-mail: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Sex: Male Female Marital Status: Married Single Widowed Divorced

Social Security Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ May we call you at work? Yes No

Name of Spouse (or parent): _____ Occupation: _____

Emergency Contact and Relationship to you: _____ Phone: _____

Person Authorized to Discuss Your Account or Medical Record: _____

Referred to our Clinic by: _____
(Thank You for Your Referrals)

I, the undersigned agree that the above information is true and correct to the best of my knowledge:

Patient Signature *(or legal guardian if minor)*: _____ Date: _____

Confidential Patient Information (HIPAA)

HIPAA:

Due to the Health Insurance Portability and Accountability Act (HIPAA), we are required by Applicable federal and state law to maintain the privacy of your health information. We are also required to give you a Notice about our Privacy Practices, our legal duties and your rights concerning your health information.

Do you want a copy of our Notice of Privacy Practices? *(Please Circle)* Yes No

If "Yes" it is your responsibility to acquire a copy from Parliament Chiropractic, LLC

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2556 E. Tudor Road Ste.201

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Phone: (907)222-5100 Fax: (907) 522-5412

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Insurance Information and Financial Policy

Are you personally insured? Yes No

And/or are you insured under your spouse's or any other policy? Yes No

Are you insured by Medicare or Medicaid? Yes, which one: _____ No

Primary Insured's Name: _____ Date of Birth: _____

Insurance Company: _____ Policy No: _____

Secondary Insured's Name: _____ Date of Birth: _____

Insurance Company: _____ Policy No: _____

Guarantor Information:

Name: _____

(Last)

(First)

(Initial)

Relationship: _____ SS#: _____

Phone: _____ Work Phone: _____

In exchange for Parliament Chiropractic, LLC (Clinic) forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows:

I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjusters responsible or claims filed by me, administrative agencies, the Alaska Workers' Compensation Board and my attorneys. To the extent of my unpaid bill to the Clinic, I hereby irrevocably assign to said Clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative and direct my legal representative that at the time of final judgment, final disposition or settlement this assignment shall have priority over all others not entitled by law of superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company; employer or legal representative shall be paid **directly** to Parliament Chiropractic, LLC and will be credited to my account upon receipt. If payment is insufficient to pay for all my indebtedness, I will remain liable to Parliament Chiropractic, LLC for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, are charged directly to me and that **I am personally responsible for payment** and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. **If my account balance exceeds \$7,500, I agree to set up a payment plan, as needed, to continue treatment at Parliament Chiropractic.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such an event, I agree that this assignment will remain effective until all sums I owe the Clinic are fully paid.

Patients Signature: _____ **Date:** _____

Patients SS#: _____ Insured's SS#: _____ Drivers Lic No: _____

(Legal Guardian's Signature authorizing care of a minor and Payment)

(Date)

Parliament Chiropractic, LLC
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ (Name of Individual) consent to Parliament Chiropractic, LLC (“the Practice’s”) the use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information.

I understand the risks associated with receiving chiropractic care including but not limited to herniated disks, pinched nerves in the lower spine, and stroke (vertebral artery dissection). Patients with any of the following conditions should notify their chiropractor before receiving treatment: acute torticollis, aortic aneurysm, active peptic ulcer disease, osteomyelitis, osteoporosis, ligamentous instability, primary or metastatic tumor, myelopathy, severe anxiety, untreated hypertension, vertebral-basilar artery insufficiency, restrictive lung disease, hernia, fever, contagious diseases, are under the influence of drugs, alcohol, or prescription medications, recent operations or acute injuries, skin diseases, cuts, abrasions, sunburns, Bell's Palsy cauda equina syndrome, paget's disease, inflammatory ankylosing spondylitis, inflammatory psoriatic arthritis, reactive arthritis (Reiter's syndrome), or congenital bleeding disorder.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Health History

Please Print. Thank You

Have you seen a Doctor of Chiropractic before? _____

Your Major Complaint(s) Today and the Purpose of your Appointment:

Other Doctors seen for this condition: _____
(Doctors Name) (Type of Doctor)

Diagnosis: _____ Treatment: _____

Length of care: _____ Results: _____

Have you ever been treated for any other health condition by a Medical Physician or Chiropractor in the last year?

Yes No Describe: _____

Date of Last Physical Examination: _____

TO ENABLE US TO PROVIDE AN EFFECTIVE HEALTH CARE SERVICE, WE REQUEST THAT YOU COMPLETE THE FOLLOWING HEALTH HISTORY.

Fractures or Breaks: _____
(Which Bone?) (Date?)

Surgery: _____
(Type) (Date?)

Major Accidents or Injuries (what happened and When?): _____

Current Drugs or Medications (Type?): _____

Unusual or Contagious Disease or Condition: _____
(Name of Condition)

(Date Diagnosed)

Do you presently have any health condition that we should be aware of, Such as (Please Circle):

Pregnancy Yes No Diabetes Yes No Epilepsy Yes No Heart problems Yes No Contagious Disease Yes No

Other: _____

Family: Hereditary and Constitutional factors play an important role in your health!

Have any of your Blood Relatives (Parents/ Brothers/ Sisters) Had any of the following Conditions (please circle Yes or no)

| | | | |
|---|----------------------------------|--|------------------|
| Yes No Diabetes Mellitus | Yes No High Blood Pressure | Yes No Arteriosclerosis | Yes No Gout |
| Yes No Heart Disease | Yes No Degenerative Disc Disease | Yes No Cancer | Yes No Arthritis |
| Yes No Abnormalities and Deformities of the Spine | | Yes No Curvature or Scoliosis of the Spine | |

Social and Marital: Please discuss personally with your Chiropractor any situation that is affecting your health and happiness.

Patient Signature (or legal guardian if Minor): _____ Date: _____

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Consent to X-Rays

Today's Date: _____

Name of patient: _____ Birthday: _____

I give consent for X-Rays to be taken of me and / or my child. I will not hold Dr. Parliament's office responsible for any occurrences having to do with the X-Rays that are taken at this clinic.

Signature: Patient / Guarantor _____

Guarantor Print Name _____

WOMEN: I understand that if I am pregnant and have X-Rays taken which expose my lower torso to radiation it is possible to injure the fetus. I have been advised that the 10 days following the onset of menstrual period is generally considered being safe for X-Rays.

With the full understanding of the above, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time and I acknowledge consent in the event an X-Ray examination is to be performed.

Signature: Patient / Guarantor _____

Massage Therapy Policies

Cancellation Policy

Massage appointments can be rescheduled or canceled free of charge if we are notified at least **4 business hours** before your appointment. Cancelled or missed appointments will be subject to a **\$60 cancellation fee** if the 4 hour notice was not given.

Financial Agreement

- I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
- I have read the financial policy and understand it.
- I understand I am financially responsible for all charges, whether or not they are covered by my insurance.

Therapeutic Massage Guidelines

- Arrive 30 minutes early for new patient massages and 15 minutes early for established patient massages to fill out the massage intake form and use the restroom.
- Arrive freshly showered and **free of perfumes and odors**.
- Undress to your comfort level.
- Any inappropriate or unprofessional behavior will not be tolerated. Your session will be terminated at the therapist's discretion if you fail to abide by this policy.

General Liability Release

- I understand the risks associated with massage therapy including, but not limited to, superficial bruising, muscle soreness, and exacerbation of undiscovered injuries. I therefore release the company and the massage therapist from all liability concerning these injuries that may occur during the massage session.
- I will inform the therapist of all medical conditions and medication I am taking, and let the therapist know of any changes to these. I understand there may be additional risks based on my physical condition.
- I will inform the massage therapist of any discomfort I may feel during the massage so he/she may adjust accordingly.
- I understand that I or the massage therapist may terminate the session at any time.
- I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

Sick Policy

Parliament Chiropractic wants to ensure the safety and health of our patients and employees. Please cancel your appointment as soon as possible if you are sick or start to feel symptoms of being sick in order to prevent spreading the illness. We are happy to reschedule your appointment, without penalty, until you are better. If you arrive for your appointment with symptoms of a contagious illness, you will be asked to reschedule your appointment.

A small cold for you could be a debilitating pneumonia for a patient with a compromised immune system. Receiving a massage when you are sick is also contraindicated (it can increase severity and intensity of your illness due to increased circulation of blood and lymph fluid). Please help us protect our patients and employees by visiting your primary care provider or staying home when you are sick.

I understand and agree to the above policies.

Patient (or Guarantor) Signature: _____ Date: _____



Free Consultation Release

A Free Consultation at Parliament Chiropractic is an opportunity for new or existing patients with new injuries and ailments to meet one of our experienced and compassionate doctors to discuss your condition to see if chiropractic is the right treatment for you.

What does a free consultation with the doctor entail?

- Completion of new patient paperwork
- An appointment with the doctor to discuss your condition
- A professional medical opinion and recommendation for treatment

What is not included?

- Physical examination and evaluation
- X-rays or other diagnostic imaging
- Chiropractic adjustments and treatment
- Physical therapies including massage therapy, e-stim, etc.

If you have questions about the free consultation, please direct your inquiries to our office staff. We would be happy to describe this complimentary portion of your first appointment in greater detail. Please sign below that you understand the guidelines of the Free Consultation.

Name

Date



Insurance Benefit Verification Waiver

Parliament Chiropractic offers a health insurance benefit verification as a **courtesy service** for patients who wish to bill health insurance for their treatment. Insurance benefits are verified at the time the patient provides new insurance information and are subject to change without notification to our office.

The information we receive from your insurance company during the benefit verification is not a guarantee of coverage nor is the information guaranteed to be accurate to your insurance plan. **Your insurance company states that the benefit information they give our office is only a quote.** Actual benefits will be determined at the time the claim is submitted to your insurance company.

It is your responsibility to understand the details of your individual insurance plan. We recommend that all patients contact their insurance company to verify information regarding copay, coinsurance, visit limits, prior authorization requirements, or any other coverage limitations.

Additionally, the information we provide to you is not a guarantee of the amount you will be responsible for after your claims are processed. **You are responsible for any charges not covered by insurance,** as stated in the Financial Policy on page 2 of the New Patient Packet.

By signing below, I acknowledge that I understand the above information and agree to pay any charges that are deemed to be patient responsibility by my insurance company.

X _____

Printed Name

X _____

Signature