

Moorhouse Chiropractic
4660 N. Penngrove Way STE 110
Meridian, ID 83646
Phone: (208)938-2992 Fax: (208)938-3476

Patient Name _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Occupation _____ Employer _____

Email Address _____

How did you hear about us? _____

Emergency Contact

Guardian or Spouse's Name _____

Occupation _____ Phone _____

Health History

What is your reason for seeking chiropractic care? _____

Describe any health problems, including how long you've had them. _____

Are you under the care of a Primary Care Physician? Yes ____ No ____

If Yes, state the conditions you are being treated for

List any current medications _____

List any past surgeries & dates _____

List any past accidents & dates _____

Females Is there a possibility of you being pregnant? Yes ____ No ____

Health Insurance

If you are paying out of pocket, skip this section.

Insured's Name _____ Employer _____

Insurance Company _____

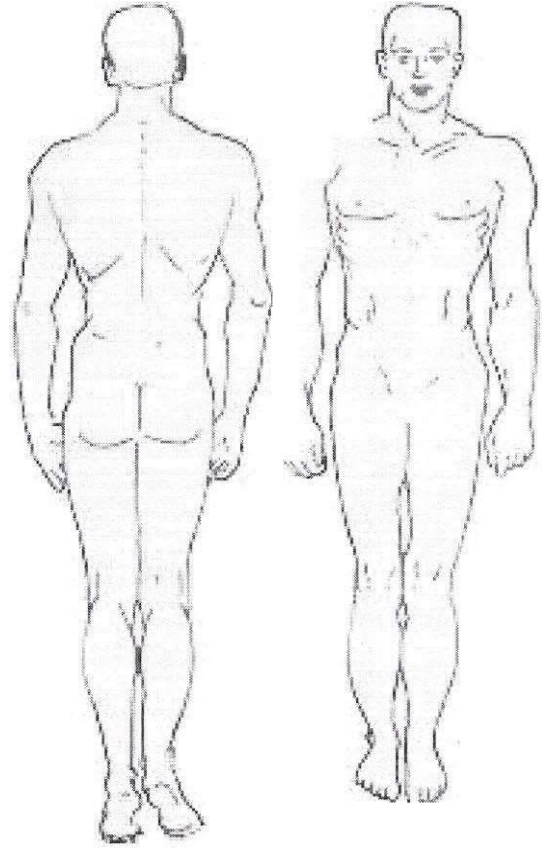
Insured ID Number: _____ Group Number: _____

Please Fill in Below

**If you have had the following, or if you suffer
From the following, *Please Check***

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	0	0
Migraines	0	0
Neck Pain	0	0
Shoulder Pain	0	0
Arm/Hand Pain	0	0
Mid Back Pain	0	0
Low Back Pain	0	0
Hip Pain	0	0
Leg/Foot Pain	0	0
Disc Problems	0	0
Arthritis	0	0
Other joint pain	0	0
Numbness	0	0
Joint Swelling	0	0
Dizziness	0	0
Nausea	0	0
Weakness	0	0
Fatigue	0	0
Nervousness	0	0
Insomnia	0	0
Heart Problems	0	0
Frequent colds	0	0
Nose Bleeds	0	0
Ringing in Ears	0	0
Earaches	0	0
Hearing Loss	0	0
Cough	0	0
Chest pains	0	0
Menstrual problems	0	0
Allergies	0	0
Asthma	0	0
Cancer	0	0
Osteoporosis	0	0
Diabetes	0	0
Hypoglycemia	0	0
Digestive problem	0	0
Urinary Problems	0	0

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Thank you for being complete and thorough.

Your Signature Below Please

Date: _____

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop” similar to the noise produced when a knuckle is “cracked,” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used. Exercises may be recommended.

Benefits of chiropractic treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series a chiropractic adjustments.

Possible Risks: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord . A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of a stroke. The possibility of such injuries occurring in association with chiropractic treatment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare” to “extremely rare”.

Other treatment options which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to the stomach, liver, and kidneys, increased cardiovascular risk, and other side effects in a significant number of cases.
2. *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these prescription drugs include all side effects as above, plus patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds additional risk of exposure to medical error, infection and other complications in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

----- patient initials

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

Printed Name

Signature

Date

Financial Policy

Thank you for choosing Moorhouse Chiropractic as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

All payments are due at the time of service. We accept Cash, Check, Visa, MasterCard, Discover and American Express.

We accept assignment of insurance benefits from your insurance carrier. However, it is the patient's responsibility to ensure that the insurance carrier meets their obligations. The contract is between you and your insurance carrier. We are not a party to that contract. All insurance must be pre-approved by Moorhouse Chiropractic credit department. If your insurance has not paid the bill within 45 days, you will be asked to make a payment on the account to stay in good standing with Moorhouse Chiropractic. We encourage you to contact your insurance company for any discrepancies.

If we are a participating provider, all co-pays and deductibles are due the day of treatment. Verification of insurance must be completed prior to the first visit.

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

CPT Billing Code	Description	Price
99201	Brief Visit	\$50.00
99202	Limited Visit	\$70.00
99203	Detailed Visit	\$105.00
98940	1-2 Area Adjust	\$50.00
98941	3-4 Area Adjust	\$60.00
98943	Extraspinal 1+	\$30.00
97014	Muscle Stim	\$25.00
97124	Massage	\$35.00/unit
97012	Intersegmental Traction	\$25.00
97010	Hot Packs	\$15.00
97010	Cyro Therapy/Ice	\$15.00
99070	Cyro Therapy/Ice/Home	\$30.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and copayments related to my care. I understand that if I have a balance for medical services not paid, after 45 days I will make monthly auto debit payments of 20% of my outstanding balance. If my balance is not paid in a timely monthly fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charge a \$25.00 service charge.

I further understand that if my insurance company declines payment, I authorize Dr. Moorhouse to file small claims on my behalf against my insurance company as a method of collection. I also understand that I will be present that the court date if needed.

I have read and fully understand the above financial terms and prices.

Signed _____ Print _____ Date _____

Moorhouse Chiropractic
Acknowledgement of Receipt of Notice of Privacy Practices

On February, 1, 2005, Moorhouse Chiropractic joined every health care provider in the country in initiating implementation of the Federal *Health Insurance Portability and Accountability Act of 1996*- known as **HIPAA**.

Our practice has always respected the privacy of those who come to us seeking care and healing. While HIPAA may be mandatory, it really is an extension of something we have been doing throughout our entire history. We continually make efforts to “*Respect Privacy.*”

In order to make sure that our patients are aware of their rights under HIPAA and how the practice may use and disclose their protected health information, we are making a concerted effort to make sure that each of our patients receives a copy of our Notice of Privacy Practices.

To help us keep track of who has and not received a copy of our Notice of Privacy Practices, please take a moment to complete the information below.

I have received a copy of the practices Notice of Privacy Practices.

I respectfully decline the receipt of a copy of the practice’s Notice of Privacy Practices.

Patient Name Legibly Written (First, Middle Initial, Last)

Date of Birth

Patient or Guardian Signature

Date

Moorhouse Chiropractic

Auto Accident Information

Name: _____

Date of Accident: _____

Where did the accident occur: _____

How did the accident occur:

Who is the insured party:

What is the name of the insurance: _____

Is this an automobile policy: _____

What is the claim number or policy number for the insurance: _____

Auto insurance phone number: _____ Fax number: _____

Insurance Contact Name: _____

Insurance Address: _____

Do you have Medpay*? _____ Amount: _____

We will assist you in filing a claim with the insurance listed above. If the claim is not settled in a timely manner, we will look to you for payment of services. You will be financially responsible for any charges not collected from the insurance company.

I have read and understand the policy above.

Patient or responsible party signature

Date

* Medical Payments coverage, also known as MEDPAY coverage, pays medical expenses for you and any passengers in your vehicle who are injured during an accident or auto-related injury.

ASSIGNMENT OF BENEFITS AGREEMENT AND AUTHORIZATION

	ATTORNEY		YOUR CAR INSURANCE		YOUR HEALTH INSURANCE		OTHER PERSON'S INSURANCE
Name:		Name:		Name:		Name:	
Address:		Address:		Address:		Address:	
Phone:		Phone:		Phone:		Phone:	
		Policy#:		Policy #:		Policy #:	
		Claim#:		Group #:		Claim #:	
		Name of Insured:		Name of Insured:		Name of Insured:	

RE: Patient Name: _____

Date of Injury: _____

I do hereby authorize Michael Moorhouse to furnish my attorney, auto medical/health insurance and/or liable insurance or uninsurance/underinsurance with a full report of case history, examination, diagnoses, treatment, treatment compliance, and prognosis of myself in regard to my accident/illness which occurred on the above date.

I do hereby give a lien and assign my cause of action and right recovery on any settlement, claim, judgement, or verdict as a result of said accident/illness, to Michael Moorhouse for the amount of any outstanding indebtedness to Michael Moorhouse for any and all service rendered in relation to this accident/illness including late finance charges added to my outstanding balance. I authorize and direct you, my attorney, auto/medical health insurance, or liable insurance or un-insurance/underinsurance, to pay directly to Michael Moorhouse such sum as may be due and owing Michael Moorhouse for services rendered to me and to withhold such sums for such settlement, claim, judgement, or verdict as may be necessary to protect Michael Moorhouse adequately and fully. I hereby agree that I will not accept settlement or payment from the liable insurance or my attorney, until you agree to pay Michael Moorhouse separately and fully for his services rendered to me in relation to this accident and I hereby direct you to not provide me with any settlement payment until such debt to Michael Moorhouse is fully paid. I authorize said provider to file a lien(s) with the appropriate county recorder's office against any settlement, claim, judgement, or verdict, and direct you to honor such lien, as a legally binding encumbrance upon the proceeds of my settlement. Further, I hereby direct you to abide by this agreement and directive I have made with Michael Moorhouse as binding upon all parties unless canceled by mutual written agreement of myself and Michael Moorhouse.

I fully understand that I am directly and fully responsible to Michael Moorhouse for all therapy bills submitted by Michael Moorhouse for services rendered to me, and that this agreement is made solely for said provider's additional protection and in consideration of awaiting payment of Michael Moorhouse. I further understand that such payment is not contingent on any settlement, claims, judgment, or verdict by which I eventually recover of said fee. I authorize a copy of this agreement and authorization to be used in lieu of the original and declare such a copy to be valid and equally binding upon all parties. I waive the statute of limitations regarding my provider's right to recover.

Dated: _____ Patient Signature: _____

Dated: _____ Witness' Signature: _____

Dated: _____ Michael Moorhouse, DC: _____



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Billing Policy

To: All Auto Accident/Personal Injury Patients

Please note that when your insurance company, the third-party insurance company, and/or your attorney wish for you to settle your claim, please call to check on the status and amount owed on your account with us first.

Insurance companies, when wishing to settle your claims, may not have paid all outstanding billings. In such cases, after your settlement with them, you will be responsible for all outstanding bills, However, payments may be made on such accounts, so for accurate information, you will need to call.

Third Party Billing: If the doctor agrees to bill third party claims, the patient will be responsible for making monthly payments to their account until such account is settled. The amount of the monthly payments will depend on the estimated treatment plan frequency and duration and will be given at the second visit.

Maxed Medical Limits: If your medical limit under your auto insurance (MEDPAY) has been met, you will be responsible for making monthly payments until your account is settled. You may ask us to submit to your private health insurance carrier for unpaid charges. However, you will be required to make monthly payments, the amount of which will be determined by charges outstanding.

Should you have questions either during or after treatment, please feel free to give us a call anytime.

Thank you for your patronage and we look forward to treating you.

I have read and understand the billing policy for auto/personal injury claims.

Patient Signature: _____ Date: _____



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ASSIGNMENT, LIEN, AND AUTHORIZATION ASSIGNMENT OF CLAIM

Moorhouse Chiropractic agrees to treat my condition with the understanding that their services will be paid out of any insurance benefits, judgement or settlement which may be payable to me. I understand that I am financially responsible for all charges accrued with Moorhouse Chiropractic in the event no monies are paid to me. In exchange for Moorhouse Chiropractic services:

I assign to Moorhouse Chiropractic my insurance benefits, settlement or judgment proceeds which are or shall become payable to me in an amount equal to their fee for treating me. Grant them lien on those benefits proceeds for the payment of Moorhouse Chiropractic fees.

My attorney and insurance company are directed and ordered that when they have any money payable to me, they pay Moorhouse Chiropractic before anyone else, including me, is paid.

I authorize Moorhouse Chiropractic to give my attorney and/or insurance company all of the information pertaining to my case in order to secure their payment. I hereby agree to indemnify and hold Moorhouse Chiropractic, their employees, and agents free and harmless from any actions against them for alleged invasion of privacy, libel, slander, or defamation arising from or related to disclosure of such information.

I do hereby agree to assign any and all right, title, or interest to my claim against my insurance company and/or attorney or any third party for breach of contract and/or bad faith and refusal to pay the bills or claims submitted by Moorhouse Chiropractic.

I further agree to assist in and fully cooperate with Moorhouse chiropractic and its attorney in their attempts to collect on their fees and services rendered to me for which my insurance carrier and/or attorney has refused to pay. I understand the lien cannot be revoked.

I am responsible for [paying Moorhouse Chiropractic fees for treating me and at any time they can demand that I pay all or part of the balance of their fees. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover. I also agree to pay all of Moorhouse Chiropractic, their heirs, successors and assigns.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding, on all parties involved, as the original copy.

Signature

Date

Print

Moorhouse Chiropractic Representative