pain 2 WELLNESS CENTER

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that this organization originates and maintains health records which describe my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment.
I understand that this information is used to:

- Plan my care and treatment
- Communicate among health professionals who contribute to my care
- Apply my diagnosis and services, procedures, and surgical information to my bill
- Verify services billed by third-party payers
- Assess quality of care and review the competence of healthcare professionals In routine healthcare operations

I further understand that:

- A complete description of information uses and disclosures is included in A *Notice of Information Practices* which can be provided to me at my request
- I have a right to review the notice prior to signing this consent
- The organization reserves the right to change their notice and practices
- Any revised notice will be mailed to the address I have provided prior to implementation
- I have the right to object to the use of my health information for directory purposes
- I have the right to request restrictions as to how my health information may be used Or disclosed to carry out treatment, payment, or health care operations
- The organization is not required to agree to the restrictions requested
- I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon

I request the following restrictions to the use or disclosure of my health information: _____

HEALTH CARE AUTHORIZATION

The above named patient authorizes the staff of Pain 2 Wellness Center, LLC to use and/or disclose protected health information in accordance with the following specific authorizations:

1. Contact Authorization. I give permission to Pain 2 Wellness Center to use the following information, but not limited to my: address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday and any other holiday related cards, and to display a picture of my automobile accident on a bulletin board. If Health Authority contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
2. Open Room Authorization. I give Pain 2 Wellness Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor or staff at any time in private, they will provide a room for these conversations.
3. Right to Establish Payment. I authorize and grant power of attorney to any approved agents of Pain 2 Wellness Center to act with any insurance company regarding claims, payment of my treatment, and collection for bills. This includes full permission to establish a medical or accident claim, on my behalf, and create payment protection that would relate to the payment of any healthcare services. Any statements or documents, related or affecting treatment services that would prevent or deny insurance payments to this office are to be made null and void by the receipt of this form. I intently grant an assignment of benefits as letter of credit against my insurance claim(s) for direct payment to this office. I further authorize the release of any information regarding my coverage on my insurance policy, or any future claim settlement status from the associated insurance company(s) their attorney(s) and/or my personal attorney(s).

This authorization is requested by Pain 2 Wellness Center for its own use/disclosure of PHI. (*Minimum necessary HIPPA standards apply.)* You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Pain 2 Wellness Center LLC, retains the right to refuse treatment or may offer to provide treatment on a pre-paid basis.

Print Name	Signature	Date

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):_____

Parent/Guardian Signature: _____ Date: ____/____/_____

pain 2 WELLNESS CENTER

Financial Policy

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies: Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a Discount Medical Plan Organization (DMPO) that you may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care). Ask our team for more information. DMPOs CANNOT BE USED FOR INJURY CLAIMS
- If you are eligible & choose a pre-payment plan, auto-debit plan or "prompt payment" option. *We offer weekly, monthly, or yearly payment*

As part of plans. our compliance plan, our office will be unable to extend any type of discounts other than those listed above. We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. Details of your care plan will be discussed with you during your Chiropractic Report. To assist you with your healthcare investment, we provide the following payment options:

- Cash - includes money orders and **personal checks**
- Credit Cards – MasterCard, Visa, and American Express
- Auto-Pay – an auto debit payment program that uses debit cards or credit cards

Health Insurance: If you have insurance that covers chiropractic, we will file all of the information for you. This includes your diagnosis, prognosis, and copies of your records or reports. Remember, you agreement with your insurance company is between you and them. If for some reason your insurance does not pay what we expect, you will be responsible for the balance. We file your insurance only as a courtesy for you. We will discuss this option with you during your Chiropractic Report. **ALL DEDUCTIBLES AND CO-PAYMENTS** must be paid prior to service. **Special Situations: i.e. AUTO INJURY OR WORKERS COMP**
If you choose to use insurance for a special injury claim, such as an auto accident or a workers compensation injury, your "normal insurance" or DMPO will be **"frozen" until such claim is closed.** Your personal "Health Insurance" is not required to pay "third party claims". We will then continue on the corrective plan we have chosen for you at that time.

Medicare patients: Medicare offers very limited coverage for chiropractic treatment. Medicare does not cover X-ray examinations, physical examinations, extremity adjustments, hot/cold treatments, traction or other therapies performed by a Chiropractor. Medicare will only cover chiropractic spinal adjustments.

Office Fee Schedule

SERVICE		OFFICE FEE
Consultation		
99201 – 99205 Initial Exam (Brief-Comp.)		N/C-100
99211 – 99215 Est. Re-Exam (Brief-Comp.)		$100-$250
X-Rays (per view)		$50-$20 *BY REFERRAL*
98940	Adjustment (1-2 regions)	$51
98941	Adjustment (3-4 regions)	$63
98942	Adjustment (5 plus regions)	$75
98943	Adjustment (extremities)	$40
97035 Ultrasound 15 minutes or less		$45
97014 Electric Stimulation 15 minutes or less		$40
97012 Mechanical Traction 15 minutes or less		$50
97110 Therapeutic exercises 15 minutes or less		$65
97530 Therapeutic procedures 15 minutes or less		$60
97535 Self Care Home Therapies 15 minutes or less		$77
Wellness & Corrective Adjustment Plans Patient		Based on individual needs

Statement of Understanding:

I have read the 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 co-payments related to my care. I understand that if I have a balance for medical services not paid, I will make a minimum of $50.00 each month or 20% (auto-debit) of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all service, 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 also agree to Pain 2 Wellness Center filing a lien against the settlement of aforementioned case. I am aware that if my case is not settled 90 days after the end of treatment my account will be placed in collections. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.
I further understand that if my insurance company declines payment, I authorize Pain 2 Wellness Center to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.
I have read and fully understand the above financial terms, policies, and prices.

Print Name	Signature	Date

Office Policies and Procedures

In order to provide the best care for our patients, all patients are accepted for care based in the following policies:

_____(Initial) **Office Hours: Monday, Wednesday, Thursday, and Friday**, our office **will open promptly at 9:00 am**. We close daily 1:00-3:30 to allow time for staff meetings, trainings, and lunches. We close for the day **7:00 pm**, with the exception of **Thursday,** where we will **close at 1:00 pm** Our last appointment is **accepted 30 minutes before each closing time.** We are closed on Tuesdays.

_____(Initial) **Treatment Plans:** Care plans are individualized for each patient based on their individual needs, goals, and condition of their spine. It is the responsibility of the patient to follow their treatment plan to receive the full benefits of their program. Changes to treatment plans or visit frequency will be made at specific re-evaluations based on progress. Please understand that we do not base your care plan on your extended insurance coverage, and neither should you. There are limits to what they will pay. Our goal is to correct your problem in the shortest amount of time possible and in the most cost-effective manner. You will achieve the best results when you follow the practitioner's recommended appointment schedule and home care advice. Remember: healing takes time. If you do not feel satisfied with your body's responses, please request extra time for your next appointment to discuss this with your practitioner. We want you to get the most from your care.

_____(Initial) **Back Office**: Our patient's treatment and privacy are of upmost importance to our office. To stay in compliance with our privacy policies, we ask all patients to please refrain from entering the treatment area without assistance from the staff.

_____(Initial) **Reading of Reports**: If you have completed the recommended MRI or other imaging, please inform the front desk so that they may schedule a time for you to go over those results with the doctor. Remember to bring in your MRI disc provided to you at the time of your appointment.

_____(Initial) **Medical Record and Forms:** Copying and transfer of medical records requires a signed release by the patient. There is a pre-payment required before records can be copied. The fee to pick up your medical records is $25. If you want your medical records mailed, the fee is $28. Once payment is received, please allow up to 7 business days to prepare and mail records. If you would like to pick them up, we will contact you once they are ready. If you require services, documents or documentation that fall outside of our normal office visit procedures, such as: letters of medical necessity, or work equipment requests, please allow a minimum of five business days for response and/or receipt of the requested information. Due to the required time, the doctor may charge a fee of up to $200 per set of forms.

_____(Initial) **New Patient Orientation:** It is required that all patients attend a one time "New Patient Orientation" health workshop. We offer this workshop the first Tuesday of Each month. We have found that the patients who follow this recommendation GET BETTER FASTER AND SPEND LESS MONEY.

_____(Initial) **Personal Injury Patients:** Personal injury patients must stay consistent with adjustments and notify the office of any changes with adjusters or attorneys. Personal injury patients will be billed in the following order:

1. 1st Party-Med pay – Patient auto insurance
2. 3rd Party Liability – At fault party (must have Attorney representing)
3. Under or Uninsured Motorist – Patient's auto insurance
4. Personal Health Insurance – Must have proof that all other venues have been exhausted

X Ray Consent: During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required in order to administer treatment. Before we perform x-rays on any patient our office requires the patients consent for such tests to be performed.
Please read the statements below and select ONE choice

Only Initial one box. Do not initial both.

_____ (Initial) I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

OR

_____ (Initial) I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose NOT to have any x-ray at this time and release my doctor of all liabilities.

FEMALES ONLY: 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 ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam. With those factors in mind, I am advising my doctor that I am not pregnant. _____(Initial)

Our clinic reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

Statement of Understanding: *I have read and fully understand the above terms and office policies listed above.*

Print Name	Signature	Date

NO SHOW/MISSED/LATE APPOINTMENT POLICY

We, at Pain 2 Wellness Center understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 404-699-0966 or via email at office@pain2wellness.com

To ensure that each patient is given the proper amount of time allotted for their visit, short wait times, and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder text to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

1. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

2. **Any "No-Show/Missed" appointments will be assessed a $25.00 no show fee**. This fee is not covered by insurance or any personal injury case and must be paid prior to your next appointment.

3. If you arrive more than 15 minutes past your scheduled appointment time you may still be seen if our schedule permits. You will be moved to a walk in. This could result in longer wait times as patients with scheduled appointments will be seen first.

4. Multiple "no shows" in any 6 month period may result in termination from our practice.

Cell Phone Usage Policy

Pain 2 Wellness Center is a place of healing. In order to allow all patients proper relaxation, we require all phones be placed on silent upon entering the office. This includes all notification and any videos. If you receive an emergent call, **we ask you take our call outside.** Once you have completed your call, please inform the front desk staff so that the staff will know you are ready to begin treatment. **If you are unavailable, staff will move on to the next patient.**

I have read and understand Pain 2 Wellness Center's No Show/Missed/Late Appointment Policy and "Cell Phone Usage Policy" and understand my responsibility to plan appointments accordingly and notify Pain 2 Wellness Center appropriately if I have difficulty keeping my scheduled appointments.

_____ _____

Patient Name Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

_____

Staff Initials

Motor Vehicle Accident PERSONAL INJURY QUESTIONNAIRE

INFORMATION ABOUT YOU…

Name: _____ Birth Date: _____ Age: _____

INFORMATION ABOUT YOUR ATTORNEY…

Name:_____ Office Phone: ( )_____ Office Fax: ( )_____

Address:_____ City:_____ State:_____ Zip:_____

INFORMATION ABOUT YOUR ACCIDENT…

1. Date of Accident:_____ Time of Day:_____ **a.m.** **p.m**.

2. Were you the: **Driver** **Front Seat Passenger** **Back Seat Passenger** **3rd Row Passenger** **Left** **Right** **Center**

3. Number of people in your vehicle? _____

Were you wearing seat belts? **Yes** **No**
What position was your headrest: **LOW** **MIDPOSITION** **HIGH**
Did you head hit the headrest? **Yes** **No**

4. Did any part of your body strike any part of the vehicle? **Yes** **No**
If yes, what body part hit what part of the car?_____

5. Were you knocked unconscious? Yes No If yes, for how long? _____

Type of vehicle you were in: _____ was it a Car SUV Truck Van Was it: Small Mid-size Large

Type of other Vehicle:_____ was it a Car SUV Truck Van Was it: Small Mid-size Large

Was your vehicle equipped with airbags? Yes No Did they inflate? Yes No

At the time of impact were you were looking **Straight ahead** **Left** **Right** **Down** **Not Sure**

Approximate Speed of your vehicle _____ mph. Other car: _____ mph.

Were you struck from: Front Behind Left Side Right Side

Were the police notified? Yes No If yes, was a report taken? Yes No

Did EMS arrive on scene? Yes No If Yes, were you transported to hospital Yes No

In your own words, please describe the accident: _____

_____

Estimated Damage to your Vehicle: **None** **Slight** **Moderate** **Heavy**
Was your vehicle towed from scene? **Yes** **No**
Other Vehicle Damage: **None** **Slight** **Moderate** **Heavy**

16. Please describe how you felt: (*e.g. "I had a dull ache at the back of my neck"*)

a. **DURING** the accident: _____
b. **IMMEDIATELY AFTER** the accident: _____
c. **LATER THAT DAY**: _____
d. **THE NEXT DAY**: _____

_____

17. What are your **PRESENT** complaints and symptoms?

(***What Hurts the Worst Since Your Accident is #1***)

1. _____
2. _____
3. _____
4. _____

18. Have you been treated by another doctor since the accident? Yes No
If yes, by whom :_____and when: _____

19. Have you attempted to self treat at home? Yes No **With? Ice Heat Rest OTC Medications**

20. Since the injury occurred, are your symptoms: □ Improving Getting Worse Same

21. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

□ HEADACHE	□ MID-BACK PAIN	□ IRRITABILITY	□ DIZZINESS	□ BUZZING IN EARS
□ NECK PAIN	□ LOW BACK PAIN	□ FATIGUE	□ EAR RING	□ SLEEP PROBLEMS
□ NECK STIFFNESS	□ GLUTEAL PAIN	□ FAINTING	□ MEMORY LOSS	□ STOMACH UPSET
□ NUMBNESS- FINGERS	□ SHOULDER PAIN	□ LOSS OF SMELL	□ COLD HANDS	□ NERVOUSNESS
□ NUMBNESS- TOES	□ CONSTIPATION	□ LOSS OF TASTE	□ COLD FEET	□ BALANCE LOSS
□ NUMBNESS- ARMS	□ COLD SWEATS	□ DEPRESSION	□ DIARRHEA	□ FEVER
□ NUMBNESS- LEGS	□ CHEST PAIN	□ FACE FLUSHED	□ _____	□ _____

Symptoms other than above: _____

22. How many hours per night of sleep before the accident? _____Since the Accident? _____

23. Have you lost time from work as a result of this accident? □Yes □ No

Last day worked: _____ Type of employment: _____

24. Have you ever been involved in an accident before? □ **Yes** □ **No**

If yes, please describe, including dates and types of accident as well as injuries received:

Patient Signature: _____ ***Date***:_____

Extension of Credit, Lien and Assignment of Benefits

*In consideration for this office providing services to me, and because I do not have sufficient funds available to pay in advance for care; I hereby seek credit and grant a lien to this office against any and all proceeds resulting from and arising out of the negligence of a third party, causing injuries and the need for reasonable and necessary health care, which this office, shall provide. Because services are to be rendered in reliance upon this agreement, I agree this agreement shall be irrevocable after being signed. In the event I change or substitute my attorney, this lien shall be binding upon any subsequent attorney upon being furnished a copy of this agreement. This shall not imply that the services are being provided on a contingency basis. I direct any insurance company, attorney or other person who holds or later holds proceeds from my claim to apply it directly to my account at this clinic.

*If using an attorney, now or in the future, I irrevocably direct them to follow State Bar of Georgia - RULE 1.15(I) SAFEKEEPING PROPERTY – GENERAL, and direct them to honor all debts to this clinic. They can negotiate for me but my attorney is not to release funds directly to me without honoring this debt. My lawyer has a duty under applicable law to protect such third-party claims against wrongful interference by their client (me), and accordingly may refuse to surrender the property to me until an agreement is made concerning my debt to this clinic. If my attorney does not honor this agreement they will be in violation of Georgia Bar Rule 1.15(I).

*I also authorize and direct my attorney to sign any liens or letters of protection from this office.

Assignment of Benefits and Direct Payment:

*I direct my attorney, insurance company or claims adjuster, to pay any outstanding bills out of my settlement or med pay benefits, in effect; protecting any such balance and pay this money DIRECTLY to this office. I assign proceeds from my claim to **PAIN 2 WELLNESS CENTER, LLC** (Tax **02-0721783**) to pay for treatment and services rendered by this Clinic. I irrevocability request and direct that payment be sent directly to this clinic.
*I further personally guarantee payment to this office against the proceeds of any settlement, judgment or verdict. If the case does not settle the debt is still due. I also understand that I am responsible for all collection and court cost associated with collecting this debt. Payment is not contingent on receipt of a settlement. I realize that I am responsible to make sure payment is made to your office and I will update your office once a month concerning the status of my case.

I hereby authorize and direct my insurance company, insurance administrator or attorney to pay by check, and for it to be mailed directly to our office the expense benefits allowable, as payment toward the total charges for professional services rendered. I agree to pay, in a current manner, any balances of said applicable charges. I agree that this office be given power of attorney to endorse any and all drafts for payment of my bill. I understand and agree that health and accident insurance policies are an arrangement between an insurance carries and myself. I permit this office to endorse remittances for the conveyance of credit to my account. All co pays and deductibles are due at the time of service. I understand that I will be responsible for all collection or court fees involved if the account has to be sent to collections.

I have read this entire document and fully understand & irrevocably agree to it.

Signature: _____Relationship to Patient:_____ Date: _____

Printed Name: _____ Staff Witness _____