EST COBB 2014
FAMILY CHIROPRACTIC

Date: _____

Childs Name: _____

Address: _____ City: _____

DOB: _____ State / Zip: _____

Name(s) of Parent(s) or Guardian(s): _____

Cell Phone: _____ Work Phone: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: _____

Pediatrician Name: _____

Pediatrician Phone: _____

What are your chief concerns, if any, with your child's health?

_____

_____

List any other care your child has undergone with regards to this complaint (including medication):

_____

_____

Date of onset (mm/yyyy): _____

Onset was: (circle one)		
Sudden	Gradual	Associated with an event

Duration of problem or episode: (circle one)				
Minutes	Hours	Days	Months	Years

Pattern of problem: (circle one)			
Constant	Intermittent	Occasional	Cyclical

Initiating Factors: _____

Aggravating Factors: _____

How does the problem affect your child's body function and daily activities? _____

_____

Prior occurence or episodes? _____

Other health concerns? _____

Financial Policy of Cobb Family Chiropractic PLLC

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under most insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

Patients without Insurance
We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been made. We are happy to accept cash, check, or credit cards.

Group or Individual Insurance
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, or co-pays.

Worker's Compensation
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance; however, we DO NOT accept Worker's Compensation.

Personal Injury or Automobile Accidents
Please notify your auto insurance carrier of your visit to our office immediately. We do not accept third party insurance. Notify us immediately if any attorney is representing you. If you are dropped by your attorney or change representation, please notify us of any changes. Although you are ultimately responsible for your bill, we will wait for a reasonable settlement time of your claim. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Medicare
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. If you do not have secondary coverage, you are required to pay the deductible and the remaining 20% as well as any non-covered services. All other services we provide are NONCOVERED. These services include, but are not limited to, x-rays, examinations, therapies, and supplies. Medicare patients are fully responsible for charges of non-covered services. Our office completes and files the forms for Medicare at no charge.

I have read and understand the payment policy of Cobb Family Chiropractic PLLC. I certify that the insurance information that I have provided is accurate, complete, and current and that no other coverage or insurance plan exists. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Cobb Family Chiropractic PLLC and my insurance company.

I assign my right to receive payment of authorized benefits to Cobb Family Chiropractic. I request that payment of authorized benefits be made on my behalf to Cobb Family Chiropractic for any services furnished to the patient listed below by Cobb Family Chiropractic physicians and health care providers. I authorize Cobb Family Chiropractic to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.

If my Health Insurance Plan will not direct payment to Cobb Family Chiropractic, I agree to forward to Cobb Family Chiropractic all health insurance payments which I receive for the services rendered by Cobb Family Chiropractic and its health care providers.

I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Cobb, those fees will be due and payable immediately.

Patient/Guardian Signature: _____ Date: _____

Patient Health Information Consent Form (HIPAA)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

The following person (s) have my permission to receive my personal health information:

1. _____

2. _____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient/Guardian Signature: _____ Date: _____

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Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and, if necessary, diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by the Chiropractor and/or anyone working in this office authorized by the Chiropractor. I further understand that such chiropractic services may be performed by the Chiropractor and/or other licensed Chiropractors who may treat me now or in the future at this office. I will have an opportunity to discuss with **Dr. Michele Cobb** and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the Chiropractor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Chiropractor to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my Chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient and/or the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated).

Patient/Guardian Signature:_____ Date:_____

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Office Policies

1. You should be aware that the capabilities of many modern cell phones or mobile devices, such as photo, audio or video recording may make our patients uncomfortable and may infringe upon their rights to confidentiality. Please avoid using your cell phone or other mobile device in the presence of a patient, or around their protected health information. We ask that you mute, silence, or turn off your cell phone while in our office.

2. If you bring outside food or drink into the office or exam rooms, please be mindful of our equipment and any debris remaining.

3. We schedule our appointments so that each patient receives the right amount of time to be seen by our staff. That's why it is very important that patients keep to their scheduled appointments and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Cobb Family Chiropractic sends text message reminders one day and two hours in advance of the appointment time. Should you need to cancel your appointment please call the office at 409-835-7676.

We understand that patients sometimes need to reschedule appointments. Scheduled appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "No-Show".

4. If a patient does not cancel or reschedule with at least 24 hours' notice, we will assess a $35 "No-show" service charge to their account. After three consecutive no-shows to appointments, our office will remove the remaining appointments from the schedule. Patients being treated under a Letter of Protection (LOP) from an attorney are responsible for any No-Show Service Charge(s).

Our goal is to offer the best possible chiropractic care with personal care. We hope you understand our decision and look forward to seeing you at your next appointment.

Patient Signature: _____ Date: _____