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Osborne Family Chiropractic

4965 Stone Falls Center, Suite 7 • O'Fallon, IL 62269 • Office (618) 622-9780 • Fax (618) 622-9782

Corey A. Osborne DC, DIBAK, DCBCN, DCCN, QNCP

Taelyong L. Hwangbo DC · Sasha H. Tran DC

These forms help us understand more about your health and potential needs. The more you answer, the better equipped we are to serve you, but we recognize that not every question is comfortable to answer. If you don't feel comfortable answering certain question(s), you can skip it and talk about it during your visit with your practitioner.

Patient Name: _____

Date: _____

Timeline of Symptoms

_____

_____

_____

Previous Chiropractic Care? ☐ Yes ☐ No *If yes, for what condition*?

_____

We offer a variety of services in our office. What type of care are you interested in?

☐ Chiropractic (**circle**: Spinal Pain Relief **OR** Non-Spinal Relief (i.e elbow, knee)

☐ Applied Kinesiology (i.e. food sensitivity testing, etc.) ☐ Acupuncture

☐ Functional Medicine (i.e. lab testing, holistic approach, etc.) ☐ Clinical Nutrition

☐ Neuro Emotional Technique (NET) ☐ K-Laser Therapy ☐ Quantum Neurology (QN)

Goals:

For Office Use Only:

☐ Patient information entered in EMR/PM _____on_____.
Initial Date

☐ Patient portal activated by _____on_____.
Initial Date

☐ Good Faith Estimate given by _____ on _____.
Initial Date

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OFFICE FINANCIAL POLICY

Thank you for choosing us as your Health Care Provider. Our office is dedicated to rendering the highest quality of care possible, to make you the **absolute healthiest you can be**. We also go to great lengths to make your experience here a pleasant one. For that reason, we wish to inform you of our policies, so that we can all avoid problems or confusion in the future.

1. We accept all major credit cards, checks and cash. If you pay with a credit, debit, HSA or Flex Spending card, a 4% processing fee will automatically be applied to your total amount due. If you pay with cash or check, you will pay the exact amount that is due.
2. **All patients** are considered on a cash basis until an explanation of benefits (EOB) is received from their respective insurance and the coverage is confirmed.
3. All nutritional supplements are non-covered items and payment is expected upon receipt. **Supplements cannot be returned once they have left the office. This is because the FDA deems supplements as food items.**
4. Acupuncture is considered a cash or a non-covered service unless otherwise verified by the patient with their insurance.
5. Applied Kinesiology, Neuro Emotional Technique, Vagal Stim therapy, Kinesio taping, K-Laser therapy and vial testing are considered a cash only, non-covered service; therefore, the payment is due at the time of service.
6. All Nutrition cases will be sent to insurance (where applicable) but may be a non-covered service. In that case, the patient will be responsible for all charges.

For INSURANCE Patients:

1. Quoted insurance benefits are **NOT** a guarantee of payment until it is processed.
2. **Insurance assignment** means that we will receive checks directly from your insurance company on your behalf (so that you don't have to pay us in full for services rendered at each and every visit). This service is done as a **courtesy** to you and only for **In-Network** insurance providers (Blue Cross Blue Shield and Medicare). For patients with out of network insurance policies, a superbill may be provided upon request, to be submitted for possible reimbursement.
3. We accept assignment for Active treatment plans only. Any follow-up visits/maintenance care will be payable when services are rendered. Once you have been discharged from active care and placed on enhancement/maintenance care, we will continue to file your In-Network insurance but require full co-payment and/or non-covered service payment at the time of service.
4. We gladly do the work of processing **your In-Network insurance claim and sending in the bills, as well as doing a reasonable degree of follow-up, but please remember that your insurance policy is a contract between you and your insurance company**. **You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason**. We are only a third party, they are not responsible to us, so your balance remains your responsibility whether your insurance company pays or not.
5. This office will resubmit a claim **ONE TIME**. We will not enter into any dispute with your insurance company. If coverage problems arise, **you** will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
6. Upon receiving any worksheets or EOB's (Explanation of Benefits) from your insurance company that you have questions about, please bring them to our attention. If you should receive a check from your insurance company,

while OFC has assignment, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All insurance payments, **regardless of which company issues a check first**, are applied to your account as long as any balance is due.

Any services not covered or coverage reductions by your insurance will be the patient's responsibility, unless we are contracted with your insurance.

If you have questions concerning this or any other matter, please speak with the front desk prior to seeing the doctor.

9. Should you discontinue care for any reason, other than being discharged by Dr. Osborne, you agree that any and all balances become due immediately and payable in full, since it may become difficult for us to follow-up on your insurance claim. It will become your responsibility to be reimbursed by your insurance company.

ADDITIONAL INFORMATION

Payment is required at the time of service. Any balance carried over 60 days, other than previously agreed upon financial arrangements, will become an interest accruing account. Any balance over 90 days will be turned over to a collection agency and ***you will be responsible for any collection fees, attorney fees, and/or court costs accrued.***

We require at least a 24-hour notice of cancellation. A fee of $45 will be assessed for missing 2 visits within a (1) year calendar period. For every missed appointment after that, the patient will be charged the $45 fee. The fee will have to be paid before you can schedule any follow up appointments.

At the discretion of the Doctor and staff, we will schedule (1) Saturday per month appointments. If there is a cancellation without a 24-hour notice, a fee of $50 will be assessed. If there is a no call/no show, the patient will no longer have the ability to schedule appointments on a Saturday. The fee will have to be paid before you can schedule any follow up appointments.

Dr. Osborne and/or another associate doctor may suggest laboratory work be done in order to create a care plan for you. You have the right to choose a lab for the testing, one of which OFC may not have any affiliation, but it is not guaranteed your insurance company will cover the charges. Therefore, you will be held responsible for the bill in its entirety, and it could result in a significantly larger balance. We will work with you to find the best pricing option, which is usually the cash discount price.

We do not accept Workers Compensation (Work Comp) cases. We will only accept Personal Injury (PI) cases if they are submitted through your Medical Payments policy under your Auto Insurance. If your Medical Payments benefits become exhausted, you will be responsible for any remaining balances.

If you do not have Medical Payments under your auto insurance, you will be responsible for the full payment at the time of service.

There will be a $10 service charge for all returned checks.

Since the information, policies, and benefits described here are subject to change, I acknowledge that revisions to the financial policy may occur. All such changes will be communicated through official notices, and I understand the revised information may supersede, modify, or eliminate existing policies.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Print
Patient
Name_____

Patient
Signature_____

Date_____

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About you

Today's Date_____/_____/_____ E-mail_____

Patients Name_____ What do you prefer to be called? _____
Last First MI

DOB _____/_____/_____ Age: _____ Gender:_____ My Current Gender Identity is:_____

My Sex Assigned at Birth is:_____ My Preferred Pronouns Are:_____

Mailing Address_____

Home/Cell Phone: _____Work Phone: _____Other: _____

SS# (optional, can be used for checking in)_____Referred By: _____

Insurance

Company Name: _____ Insured Name (if different from yours) _____

Relation: _____DOB of Policy Holder_____

In Event of Emergency

Who should we contact? _____Relation: _____Phone # :_____

Do you have any medication allergies?

__No known medication allergies
__Yes. What? _____

Are you currently taking any medications? **Please Print Clearly**

__Not currently prescribed any medications
__Yes...

What? _____ _____mg What? _____ _____mg

What? _____ _____mg What? _____ _____mg

What? _____ _____mg What? _____ _____mg

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CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other procedures on me or on _____ by Corey A. Osborne DC, DIBAK, DCBCN, DCCN, QNCP and/or other licensed Doctors of Chiropractic who may be employed by or engaged in practice in the Osborne Family Chiropractic clinic.

I have had an opportunity to discuss with Corey A. Osborne DC, DIBAK, DCBCN, DCCN, or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known by the doctor at the time; that is not reasonable to expect the doctor to anticipate or explain all risks and complications: that an undesirable result does not necessarily indicate and error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which they feel at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedure should know of possible complications which have been alleged. These include, but not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content, and by signing below, acknowledge my understanding of its contents.

Date: _____

_____

Patient Name

_____

Patient's Signature

_____

Relationship/authority if not signed by patient

DOCTOR'S NOTES-

Patient counseled using the following:

Discussion_____

Other (please specify)_____

X_____

Doctor's signature or other

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HIPAA Notice of Privacy Practices Consent Form

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. Patients that have Blue Cross Blue Shield of Illinois (BCBSIL) as their insurance provider: Patient records may be disclosed for risk adjustment activities required by the Patient Protection and Affordable Care Act (PPACA).

4. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; or b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; or c) by calling my cellular phone and leaving a message on the voicemail.

5. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

6. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

7. Under the 21st Century Cures Act, I have the right to access my electronic health information (EHI), structured and/or unstructured, at no cost, in the manner that I request, if the practice is able

8. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
9. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I furthermore acknowledge that I have the right to authorize access and disclosure of my PHI to anyone of my choosing for scheduling, billing, condition, treatment and prognosis to the following individual(s):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

I request the following restriction(s) to releasing my PHI:

10. I understand that I have the right to revoke the access and disclosure of my PHI authorization at any time with written notice.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

EFFECTIVE DATE
This Notice (form) is in effect as of 04/01/2022.

_____ _____
Name of Individual (Printed) Signature of Legal Representative

_____ _____
Signature of Individual Relationship
(e.g., Attorney-In-Fact, Guardian,
Parent if a minor)

Date Signed ____/____/____

Witness: _____