Taylor Chiropractic

Dr. Jeff Taylor • Dr. Brett Taylor
911 Dix St., Suite D • Otsego, MI 49078
269-694-5871

Patient Information

Name: _____

Height: _____ feet _____ inches **Weight:** _____ lbs **Right or Left Handed**

Birthdate:_____ **Email:**_____

Home Phone:_____ **Cell Phone:**_____

Home Address:_____**Zip Code:**_____

Employer:_____

Emergency Contact:

Name:_____ **Relation:**_____
Phone:_____

How did you hear about our office?_____

Insurance Information

Type of Insurance:_____

If the Policy Holder is different than the patient, the following information is needed for billing:

Policy Holder Name: _____
Date of Birth:_____**Relation to patient:**_____
Policy Holder Address:_____

Medication History

Do you have any medication allergies? **Yes** **No** If yes, what?_____

Are you currently taking any medications? **Yes** **No**

If yes, please list below or bring a list of the medications you are taking with you

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Medical History

Please list any current or past medical conditions (diabetes, cancer, ect.): **If None please put NONE:**

_____

Primary Physician:_____

What is the reason for your visit today:_____

What is the onset date of your injury/pain: _____

Family Medical History

Please list any current or past medical history of family members (diabetes, cancer, ect.)

Maternal:_____
Paternal:_____
Siblings:_____

Social History

Do you use: **Coffee** **Alcohol** **Tobacco**

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former Smoker
- ☐ Never Smoker

Marital Status: S M D W

Do you have children: yes no

If so, how many:_____

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Financial Agreement

We, the staff at Taylor Chiropractic, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact Leesa Kowal or Penny Brown at 269-694-5871. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, Care Credit and in-state checks). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest

Interest of 1.5% will incur if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

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It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.

It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports or extra-curricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $25.00 but not to exceed half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and

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service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: _____

Date: _____

For Office Use Only

Employee:

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Waiver of insurance billing

You have registered as a **cash/private pay patient.** This means that at the time of service you will be paying by cash, check, or credit card. Due to this cash payment you are receiving a discount. We will not bill insurance for services provided under this arrangement.

Fee Schedule:

New Patient first appointment: $79-$99

Adjustment:

1 region:	$35
2 regions:	$45
3 Regions:	$55

Therapies:	$10 per visit
Consultation:	$55
X-Ray:	$50-$135
Re-Evaluation:	$55

Please talk to the office manager if you have any questions regarding this arrangement.

I agree to:

1) pay at the time of service or set up a payment plan

2) waive insurance billing by Taylor Chiropractic

Patient or guardian signature_____

Date_____

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Therapy Coverage

Taylor Chiropractic will do everything possible for the benefit of our patients. Many times the Doctors will order different therapies as part of your treatment. Although some insurance companies may cover these therapies, many do not. This form is to notify you that your insurance coverage will not cover these therapies. Therapy charges will not exceed $10 per visit, even if more than one has been administered.

These therapies and their benefits are:

Electrical Therapy

- Penetrates deep into the muscle and reduces fluid
- Normalizes muscle tone
- Reduces swelling
- Helps increase muscle strength

Decompression

- Relieves spinal nerve pressure
- Relieves sciatica pain
- Helps to reduce disc protrusion
- Opens spinal segments

Ultra-Sound Therapy

- Sound waves penetrate deep via lotion
- 'Shakes' cells and breaks up adhesions and abnormal calcium deposits
- Increases blood flow
- Relaxes muscles and reduces soreness

Trigger Point Therapy

- Increased range of motion
- Decreased muscle stiffness and tension
- Improved circulation
- Fewer muscle spasms

If Therapy is recommended as part of your treatment and you wish to decline this service, please notify your doctor and/or chiropractic assistant.

☐ I understand that I will be liable for therapy charges.
☐ I decline all therapies and do not wish to be charged an additional fee

_____ _____

Patient or guardian signature Date