Welcome!

Oldroyd Sports & Family Chiropractic
REGISTRATION FORM

Section I: Patient Information

Name: _____ Today's Date:_____
Address:_____City:_____State:_____Zip_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____)_____
Email Address_____
Receive e-mail or text reminders? **E-mail** ☐ **Text** ☐ Cell Phone Provider_____
Date of Birth: _____ Social Security Number: _____ Gender: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Employer_____ Occupation_____ __Spouse or Parent's Name: _____

Race: ☐American Indian ☐Asian ☐African American ☐Pacific Islander ☐Caucasian ☐Decline to provide

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Decline to provide
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ Relationship to Patient: _____
Address: _____ ☐ same address as patient
City: _____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____
Signature of Responsible Party: _____ Date:_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Address of Employer: _____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address: _____ Ins Co. Phone:_____
(Please give your insurance card to the receptionist to be copied)

---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

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Health History

Name: _____DOB:_____ Date: _____

Addressing issues that may have brought you to our office **Date of Onset:_____**

Please briefly explain what brought you to our office today:

_____

On a scale of 1 – 10 describe your pain level: (1 = none / 10 = extreme)

Does this interfere with: ___Work ___Sleep ___Walking ___Hobbies ___Leisure ___Other

Have you seen anyone else for this issue? ____yes _____no If yes, who? _____

Childhood History: *Circle all that apply*

Did you have any childhood illnesses?	**Yes**	**No**
Did you have any serious falls as a child?	**Yes**	**No**
Did you play youth sports?	**Yes**	**No**
Did you take Medications?	**Yes**	**No**
Did you have surgery?	**Yes**	**No**
Have you fallen / jumped from a height over three feet?	**Yes**	**No**
Were you in any car accidents as a child?	**Yes**	**No**
Was there any prolonged use of medicine such as antibiotics or an inhaler?	**Yes**	**No**
Did you suffer any other traumas (physical or emotional)	**Yes**	**No**

Adult – (18 to present) Circle One

Do you currently smoke?	**Yes**	**No**
Do/did you drink alcohol?	**Yes**	**No**
Have you been in any accidents?	**Yes**	**No**
Have you had any surgery?	**Yes**	**No**
If yes, list here: _____ _____		
Do/did you play adult sports?	**Yes**	**No**

Rate these following as Poor, Good, Excellent:

Diet: _____ What do you eat? _____

Exercise: _____ When and what? _____

Sleep: _____ Hours per day? _____

Medication Allergies: _____

Additional Allergies:_____

Current Medications: _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

Family Health Profile:

At our office we are not only interested in your health and well being but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____Spouse:_____Mother:_____

Father: _____Brother(s):_____Sister (s):_____

Signature _____ Date: _____

OLDROYD CHIROPRACTIC Patient:_____

DISCLOSURE & INFORMED CONSENT TO CHIROPRACTIC CARE

You have the right, as a patient, to be informed about your condition and diagnosis. You also have the right to be informed about the recommended chiropractic procedures to be used, so that you may make an informed decision about your treatment. Once informed, you may make the decision to undergo treatment knowing the potential risks and hazards involved. By signing this agreement, I acknowledge that I have been consulted about my diagnosis and the recommended treatments. I understand and I am informed of the risks involved in my treatment, including, but not limited to, fractures, disk injuries, strokes, dislocation, sprains, increased symptoms, and pain. I further acknowledge that NO GUARANTEES OR ASSURANCES have been made to me concerning the results intended from the treatment.

I hereby request and consent to the performance of chiropractic procedures and care, including physiotherapy from Oldroyd Chiropractic, Brian R. Oldroyd, D.C., and/or other licensed Doctors of Chiropractic, or those treating me, employed at Oldroyd Chiropractic.

_____ _____

Signature (parent or guardian if patient is a minor) Date

CONSENT FOR USE OF DISCLOSURE OF HEALTH INFORMATION

Our Pledge to You: We are dedicated to protecting your privacy. Although this disclosure is required by law, please know that we respect the privacy of your health. However, there are circumstances that require that we may have to use or disclose your health care information. Your information may be used or disclosed in the following circumstances: 1) We may disclose your health information to another health care provider or a hospital for the purposes of diagnosis, assessment, and/or treatment. 2) We may disclose your health information to obtain a payment from you, an insurer, or a third party responsible for your payments. 3) Your health information may be disclosed for the purposes of treatment, quality control, staff evaluations, and to train new staff members. 4) Your health information may be disclosed to remind you of appointments, send you birthday cards, to say thank-you for a referral, to send you an office newsletter, and/or to invite you to a Patient Appreciation Day. 5) Your signed Success Story may be used for promotional purposes.

If you need more information on how your health information may be disclosed, please ask. We have a detailed description of how your health information may be used or disclosed. We reserve the right to change our disclosure policy and implement those changes at any time. You may pick up or call for a copy of the policy from our office at any time.

Your Right to Limit Uses or Disclosures: You have the right to limit how we use or disclose your health information. If you desire to limit how we use your information, please do so in writing. However, we are not required to agree to your restrictions. If we do agree, then the restrictions are binding on us.

Your Right to Revoke Your Authorization: You may revoke your consent at any time in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest your claims.

I have read and agree to the above consent policy. I acknowledge I have received a copy of the office "Notice of Patient Privacy Policy.

_____ _____

Signature (parent or guardian if patient is a minor) Date

MEDICARE PATIENT AGREEMENT **(Required by Medicare for all Medicare Claims)**

_____ _____

Entitlee's Name Medicare Subscriber Number

I hereby request that payment of authorized Medicare benefits be made on my behalf to Oldroyd Chiropractic, Brian R. Oldroyd, D.C., for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it in writing.

_____ _____

Signature (parent or guardian if patient is a minor) Date

OLDROYD CHIROPRACTIC Patient:_____

FINANCIAL POLICIES

Our office offers two methods of payment for services rendered. Please check one of the following and sign below:

□ **Self-Pay** Definition: Under this payment method, charges for services are paid in full immediately after they are rendered and no paperwork is performed or monthly billing done. By reducing the cost of bookkeeping, we are able to offer our self-pay patients reduced fees for services.

□ **Insurance** Definition: As a professional courtesy to our insured patients, we bill insurance companies for services rendered. The fee schedule is higher than self-pay as an insurance plan requires considerable claims preparation, insurance verification, authorization requests, completion of forms and possibly copying of records and report writing for medical necessity. WORKERS COMPENSATION and AUTOMOBILE NO-FAULT INSURANCE may cover your chiropractic treatment. If you have been injured on the job or in an automobile accident, PLEASE notify us immediately so that we can file the proper forms.

Insured Patients: Our financial relationship is with **YOU**, not with your insurance company. When we verify benefits, and as a courtesy to you, we will try to give you general guidelines about what your insurance policy might cover. Since insurance is an agreement entered into by you and your insurance carrier, you are ultimately responsible for knowing the specifics of what your policy covers. Although insurance coverage has been verified, not all services may be covered.

As a contract provider for your insurance company, we accept the fee allowance from your insurance company as our full fee **for covered services**. As you know, insurance company benefits and limitations vary widely. What this means is that on each visit you are required to pay your co-payment, **non-covered services**, and/or deductible. We bill your insurance and they pay the contracted amount, minus your co-payment and/or deductible for covered services. If there is an amount left over we discount the amount as a contractual reduction and your fee is considered paid in full.

Also, it is important to note that regardless of how many visits an insurance company says are available, they only pay for visits they determine are medically necessary, **under their definition of medically necessary**. Many times your insurance company's definition of medical necessity is based on an acute pain model of 5-8 visits instead of what you really need to reach maximum improvement and stay there. **As such, visits above 5-8 visits per condition may be considered not medically necessary and a non-covered service**.

ALL PATIENTS are REQUIRED to PAY IN FULL at the time of each visit. If the entire amount cannot be paid, it is expected that the remaining balance will be paid within 60 days of the date of service. A FINANCE CHARGE of 1.5% of the unpaid balance or $5.00, whichever is greater, may be assessed monthly to your account on any services that remains unpaid 60 days after the date of service, unless other financial arrangements have been made. If collection has to be made by suit or otherwise, the patient or legal guardian of minor child will be responsible for any and all fees incurred, including court costs, attorney fees, and interest. We accept cash, checks, money orders, credit and debit cards. Payment for orthopedic supports, supplements, and other supplies is required at the time of purchase. Special orders must be paid for at the time the order is placed.

Returned Check Policy: A finance charge of $25.00 will be charged for returned checks.

Cancellation Policy: Patients must give notice to the office of any cancellations or rescheduling of appointments within 12-24 hours of the scheduled appointment. Failure to give notice will result in a $20 late cancellation fee being assessed on the account.

□ **As a Self-Pay Patient**, by signing this agreement, I acknowledge that I have read and understand the financial policies above and I agree to be responsible for all charges incurred by me for services rendered in this office.

□ **As an Insured Patient**, by signing this agreement, I acknowledge that I have read and understand the financial policies above and I agree to be personally responsible for all co-payments/co-insurance, deductibles, non-covered services and any other amounts not covered by my insurance. Furthermore:

I hereby authorize the release of any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges.

_____ _____

Signature (parent or guardian if patient is a minor) Date

_____ _____

Oldroyd Chiropractic Authorized Representative Date

Oldroyd Chiropractic – Arbitration Agreement

YOU ARE HEREBY REQUIRED TO ARBITRATE ANY AND ALL CLAIMS AND WAIVE ANY RIGHT TO HAVE YOUR CLAIM HEARD BY A JUDGE OR JURY.

The arbitration panel's decision shall be binding on all parties. You, the patient, are responsible for one-half of all arbitration related costs.

This agreement will automatically renew each year from the date of signing unless you cancel this agreement in writing before the renewal date.

You have the right to ask questions about this agreement.

You have the right to rescind this agreement, in writing, within ten (10) days from signing the agreement.

You have the right to require mediation of the dispute prior to the arbitration of the dispute.

The arbitrators shall be selected as follows:

a. One arbitrator shall be selected by all persons claiming damages.
b. One arbitrator shall be selected by Basic Health.
c. A third arbitrator shall be jointly selected by all persons claiming damages and Basic Health.
    1. If both parties cannot agree on the selection of third arbitrator the other two arbitrators shall appoint the third arbitrator from a list of approved arbitrators by the state or federal court of Utah.
d. A single arbitrator may be selected, if both parties agree.

You have the right to decline to enter into this agreement. If you elect to decline to sign this agreement you may still have the right to medical treatment.

All Parties WAIVE the requirement of Section 78-14-12 to appear before a hearing panel in a malpractice action against a health care provider.

You have the right to retain legal counsel, but are responsible for your own attorney's fees.

This agreement shall apply to errors and omissions that occur after this agreement has been signed. This agreement does not prevent persons who would be a proper party in court to participate in an arbitration proceeding.

_____
Patient Name

_____ _____ _____
Signature (patient or guardian) Relationship Date