

Welcome to Angelo Chiropractic & Acupuncture

Thank you for choosing our office for your healthcare needs. We will determine if Chiropractic/Acupuncture and its associated treatments are best suited for you. We strive to provide the highest quality of care possible. If our modes of care are not indicated, or need to be co-managed we will recommend a healthcare practitioner to best serve your needs.

Angelo Chiropractic & Acupuncture treats patients of all ages, backgrounds, and needs—including families, athletes, newborns, expecting mothers, the injured and sick, and those who wish to maintain their health. We are HIPPA compliant; we will not release your medical information without written consent from you. A Privacy Policy and informed consent will be provided for your protection and review.

Payment Policy

Payment is due/expected for fees incurred on the date of service, including co-pays, deductibles, coinsurance, or remaining balance. Full payment is due until benefits are verified unless other arrangements are made. Payment is accepted by CASH, CHECK OR CREDIT CARD.

Insurance and Managed Care

We are contracted providers for many local plans; our participation in these plans can vary year to year. If you are under a managed care plan or health, coverage of this plan will be explained to you once verified. A quote of verification of your benefits is not a guarantee, but a general quote or estimate. This cannot be completely confirmed until the first claim is submitted and paid within thirty days from your first appointment. Benefits of your plan for Chiropractic can vary by policy. Some have limits on visits per year or dollar limits per year. These benefits may or may not cover your specific needs. We will inform you of your needs and allow you to make an informed decision. Know always that we treat patient is needs and not their insurance policy. Care beyond plan limits is the responsibility of the patient. Acupuncture, orthotics, bracing, supplements, herbs, and vitamins are on a self-pay basis. A receipt can be given for insurance or use for an HSA account.

Medicare

Traditional Medicare covers ONLY spinal manipulation provided by a Chiropractic Physician., up to twenty-four visits per calendar year at 80% of the charge once the yearly deductible is met. The remaining 20% is covered by either a secondary policy or by the patient at the time of visit. Medicare DOES NOT cover x-rays, lab work, physical therapy (i.e., traction, electrical therapy, ultrasound, massage). These costs are the responsibility of the patient at the time of service. Medicare Select plans operate like private insurance and vary from policy to policy on deductible amount, and what is covered.

Privacy Practices

This office is required to notify you in writing that by law, we must maintain the privacy and confidentiality of your personal health information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we

are permitted to disclose information about you to a third party without your authorization. Below is a summary of these circumstances.

Permitted Disclosure

Treatment Purposes-discussion with other health care providers involved in your care.

Inadvertent Disclosures-discussion in open office area.

For Payment Purposes-to obtain payment from your insurance company or another source.

Emergency-in the event of an emergency, we may contact a family member.

For Public Health or Safety-in order to prevent or lessen a serious eminent threat to the public.

Telephone Calls and Appointment Reminders-we may call, text, or leave messages regarding appointments, testing, practice hours or upcoming events.

Change of Ownership-in the event this practice is sold, the new owners would have access to your personal health information.

Personal injury/Automobile accidents

If you have been involved in an accident inform us immediately. Accidents require specific documentation, examination, and specific billing procedures. Incorrect documentation could affect a patient's case (i.e., treatment, lost wages, settlements, etc.) Once the claim is settled or if you suspend or terminate care, fees for services are due immediately. A person's PIP (Personal Injury Protection with car insurance) can be used for healthcare. We also accept LOP's (Letter of Protection) from certain attorneys we have worked with previously.

Timely appointments

I understand that when reserving an appointment that I and my doctor are reserving time for my care, and if not utilized prevents another from receiving care. Therefore, for Angelo Chiropractic and Acupuncture to provide timely service to all patients, this office requires a 12- hour minimum cancelation notice, the charge will be for an office visit if not adhered to. Recurrent no shows or reschedules will be required to keep a credit card on file.

Signature states understanding of all written policy and conveys any assignment of insurance benefits to Angelo Chiropractic & Acupuncture Center.

Signature of Patient, Parent or Guardian

Date

Welcome to Angelo Chiropractic and Acupuncture Center

“Where health and care come together.”

Thank you for selecting our office for your holistic needs. We will determine if chiropractic / acupuncture and its associated treatments are indicated for your health condition. We strive to provide the highest quality of care possible. If our modes of care are not indicated or need to be co-managed, we will recommend a health care practitioner to best serve your condition. We treat patients of all ages, backgrounds, and needs. We treat families, newborns, athletes, expecting mothers, the injured and sick, and those that wish to maintain their health. We are HIPPA compliant; we will not release your medical information without the written consent from you, unless it is regarding payment for your health services (i.e. insurance companies), or other health care professionals involved in your health care. A Privacy Policy and Informed Consent will be provided for your protection, review, and signature.

Payment Policy

Payment is due for fees incurred on the date of service. We offer a discount plan, if your pre-pay for five visits you will receive one visit free. If you pre-pay for ten visits, you will get three visits for free. Payment must be paid in full for all visits in order to receive free visits. Immediate family members may be included in this plan.

Timely Appointments

I understand that when reserving an appointment that my doctor and I are reserving time for my care and if not utilized this prevents another from receiving care. Therefore, in order for Angelo Chiropractic and Acupuncture Center to provide timely service to all patients, this office requires a 4-hour minimum cancellation notice. I agree that I am subject to a \$70.00 fee for failure to provide such notice. Furthermore, I understand that third party payers do not cover this cost.

Who me we thank for referring you? _____

Name _____ Home/Cell Phone _____

Address _____ Zip Code _____

City _____ State _____ Email _____

Age _____ Date of Birth _____ Height _____ Weight _____ Martial Status M W S D

Number of Children _____ Occupation _____ Employed By: _____

Emergency Contact _____ Phone Number _____

Reason for Visit _____

Allergies: _____

Medications: _____

Signature states understanding of all written policy of Angelo Chiropractic and Acupuncture Center.

Name: _____ Signature _____

Spouse/Guardian Signature: _____ Date: _____

Please be courteous and silence/turn off cell phones. We ask that you please arrive promptly to your appointment, all arrivals 10 minutes after appointment time will be rescheduled. Thank You!

Acupuncture Questionnaire

Name: _____ Date: _____

Primary Care Physician: _____

Physician's Phone Number: _____

Instructions: Fill out this form by circling or checking the boxes that apply to you at least 80% of the time. Do this quickly without thinking about it too much. Be nonjudgmental with your answers. Leave blank any boxes that do not apply to you or of which you are uncertain. There are no correct answers. Your honesty will result in a better treatment.

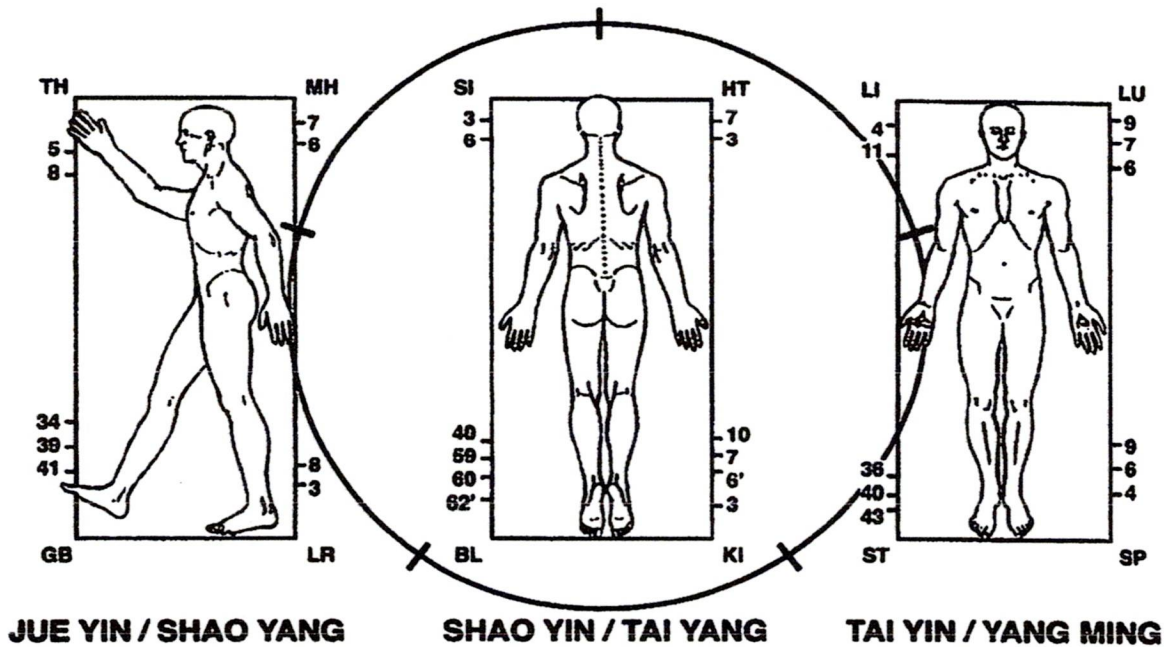
1. Start by listing in order of importance (1 being the most important) the reasons you wish to see the doctor.

1.
2.
3.
4.

2. Please circle one answer for each of the following questions

Five Phase Questions	Wood	Fire	Water	Earth	Metal
My favorite season	Spring	Summer	Winter	Harvest (late summer)	Autumn
My favorite color	Blue – Green (turquoise)	Red	Dark Blue or Black	Yellow (earth tones)	White
My favorite flavor	Sour, citrus, acidic	Bitter, roasted	Salty	Sweetness	Spicy, flavorful
My predominant emotional tendency	I tend to get angry.	I am excitable.	I get scared.	I tend to worry.	I tend to feel sad
My predominant psychological characteristic	I tend to be anxious and irritable.	I am joyful and creative.	I am willful and ambitious.	I often find myself in deep thought.	I tend to get depressed
My usual reaction to stress	I clench, my muscles get	I tend to cry.	I tremble, my body feels shaky.	My stomach feels upset.	My chest feels tight
My fingernails can be characterized as	Elongated	Long and narrow	Crescent moon	Triangular	Rectangular

3. On the anatomical figures below mark the area or areas where you have pain or other problems. Please be as accurate as possible about the locations.



Pain Assessment	Pain Assessment	Pain Assessment
Location:	Location:	Location:
Onset:	Onset:	Onset:
Makes Better:	Makes Better:	Makes Better:
Makes Worse:	Makes Worse:	Makes Worse:
Associated Symptoms:	Associated Symptoms:	Associated Symptoms:
Quality: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Pressure ☐ Burning	Quality: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Pressure ☐ Burning	Quality: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Pressure ☐ Burning
Severity: 1 2 3 4 5 6 7 8 9 10	Severity: 1 2 3 4 5 6 7 8 9 10	Severity: 1 2 3 4 5 6 7 8 9 10

Treatments I've tried: ☐ Physical Therapy ☐ Chiropractic ☐ Injections ☐ Other –
Please Explain: