Chiropractic

STRUCTURE DETERMINES FUNCTION

The body uses symptoms as warning indicators of a potentially more serious condition. A Structural Shift is just such a condition that may be the cause of your symptoms. Our office focuses on detecting and correcting these shifts so that the body can heal on its own and you can be symptom-free.

Schedule a Complimentary Consultation

We believe you should have a chance to discover if Chiropractic is right for you, and we believe that you should be able to make this discovery without any pressure or gimmicks. It is this belief that has people raving about our consultation.

Our **consultation** is a friendly conversation. During the first part of this conversation, you will get the opportunity to tell us about what brought you in. The second part will provide you with as much insight as we can relative to your health challenges. Finally, during the third part of the consultation, we will have an opportunity to tell you what we do and what sets us apart from the large community of chiropractors in the area. Our **complimentary consultation** is not a commitment. Many chiropractors have you in their examination room before you can even say "hello." That just doesn't seem right to us. After all, most people don't buy a car, and then read the brochure. It's usually the other way around. The consultation usually takes about fifteen minutes, more or less, after which you may choose to have an examination. There is no obligation. We just want you to know that exam blocks are always available immediately following a consultation. Now let's say that you're just curious about chiropractic, the varieties of chiropractic care and what sets us apart from other chiropractors in the area, but you don't necessarily want to sit down with the doctor. No problem…we got you covered. We are available to answer all questions, including duration of care, insurance, finances and just about anything you could ever want to know.

Simply download the paper work that follows and come by the office with it filled out and we will be happy to meet with you,

No Appointment Necessary

CS BLACK & NARRAGANSETT FAMILY CHIROPRACTIC

Christopher S. Black, DC phone **401-885-1545** fax **401-782-0272**

West Warwick & Narragansett, Rhode Island

Narragansett Family Chiropractic ~ CS Black Family Chiropractic ~New Patient Worksheet

Name_____ Date_____

Street_____City_____State____ Zip_____

Home Phone_____ Work/Cell Phone_____

Temporary Address_____ E-Mail_____

Soc. Sec._____Driver's Lic#_____ Sex: ☐ M ☐ F D.O.B._____

Age_____ Marital Status ☐ S ☐ M ☐ W ☐ D Occupation_____

Employer_____ Address_____City_____State___Zip_____

Billing Information:

Do you have insurance? ☐Yes ☐No Insurance Company_____

Subscriber?_____ Relationship to patient_____ID#_____

Subscriber's Employer_____ Subscriber's Date of Birth_____

Is there additional Insurance ☐Yes ☐No Insurance Co._____

Subscriber?_____ Relationship to patient_____ID#_____

Subscriber's Employer_____ Subscriber's Date of Birth_____

Is this due to an accident? ☐ Yes ☐ No Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you reported this accident? ☐Auto Ins ☐Employer ☐Work Comp ☐Other

YOUR Auto/Work Comp Insurance Co _____ Policy # _____

Address_____Phone#_____

Attorney's Name (if applicable)_____Phone #_____

Address_____City_____State_____Zip_____

Health Information:

Reason for today's visit:_____

Have you had this problem, prior to this episode?: if so when did this begin_____

_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Not sure

Rate the severity of your condition on a scale from 1 (least) to 10 (severe) 1 2 3 4 5 6 7 8 9 10

The Pain is ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Stiff

What activities aggravate your condition/pain?_____

What activities lesson your condition/pain?_____

Is this condition/pain worse at any specific time of the day?_____

Does it interfere with: □Work □Sleep □Daily Routine □Recreation □Other_____

Any home remedies?_____

Other Doctors seen for this condition_____

Have you ever received Chiropractic Care? □ Yes □ No With Whom?_____

Date of last visit_____ Why did you stop care?_____

Do you consult regularly with a medical doctor? □ Yes □ No If so, why?_____

Date of last medical consultation and result_____

What medications are you taking (including aspirin, etc.):?_____

_____How long?_____

Have you had any surgery? ☐Yes ☐No What?_____ When_____

What side effects have you experienced from the drugs and/or surgery?_____

Please list ALL OTHER health concerns, past or present. List in order of importance (example:

headaches, high blood pressure, leg pain, etc.):_____

_____

_____

_____

What are your health goals?_____

_____

Do You Exercise? ☐Yes ☐No ☐Moderate ☐Daily ☐Heavy What Kind_____

Work Activity: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor ☐High Stress

Habits: ☐Smoking ___packs/day ☐Alcohol ☐Coffee/Caffeine ☐Recreational Drugs

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated copay at the time services are rendered, including any deductibles, and further understand that the estimated copay is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual copay as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account. I understand that an interest charge at the annual rate of 18% will appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I authorize this office to contact me with information both via email or postal.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge and I will not hold Narragansett Family Chiropractic/CS Black Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. .

_____ _____ _____

Patient's Signature **Date** **Guardian's Signature**

Narragansett Family Chiropractic/CS Black Family Chiropractic

FINANCIAL POLICY AND AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. In this Agreement, "Office" and "Clinic" shall refer to Narragansett Family Chiropractic/CS Black Family Chiropractic, Christopher S. Black, DC.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). Without limiting the foregoing, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office ("Term of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any of the foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. I understand that an interest charge at the annual rate of 18% will appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges**. Our office has may discontinue care if your balance becomes greater than $150**.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ **Date**: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____/____/____

Narragansett Family Chiropractic/CS Black Family Chiropractic

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to: Narragansett Family Chiropractic/CS Black Family Chiropractic/Christopher S. Black, DC.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ **Date:** _____

Guardian (if under 18, please print):_____

Signature: _____ **Date:** _____