YAVAPAI CHIROPRACTIC CLINIC
ALEXANDER J. CARR, D.C.
142 N. RUSH ST.
PRESCOTT, ARIZONA 86301
TEL: 928-776-8230
FAX: 888-314-8148

HIPAA
Protected Health Information
Authorized Access Only

NEW PATIENT REGISTRATION

PATIENT'S CLINIC ID #: _____ DATE: _____

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

PHONE: HOME _____ WORK _____ CELL _____

EMAIL: _____ (ALL PAID INVOICES/RECEIPTS WILL BE EMAILED) DATE OF BIRTH: _____

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED SEX: ☐ M ☐ F AGE: ____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

SPOUSE'S NAME: _____ CHILDREN/AGES: _____

NAME OF LAST PRIMARY CARE PROVIDER: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

AUTHORIZATION / ASSIGNMENT

X _____ _____ X _____ _____
Patient/Guardian Signature Date Physician Signature Date

OFFICE USE ONLY:

ACCIDENT INFORMATION

Pain due to injury? ☐ Yes ☐ No

Accident Due To: ☐ Auto ☐ Personal Injury ☐ Work

Report made? ☐ Yes ☐ No

Accident Claim Number _____

Attorney's Name _____

Attorney Phone _____

INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____

Group Number: _____

Subscriber Name: _____

Subscriber SSN: _____

Insurance Card Copies? ☐ Yes ☐ No

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CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment below.

X_____ Date _____
Patient/Guardian Signature

B. I authorize payment of any medical benefits from _____ to be paid
Name of Insurance Company

directly to Alexander J. Carr, D.C., Yavapai Chiropractic Clinic, and/or Wellness Health Associates, P.C. for any services rendered to me.

X_____ Date _____
Patient/Guardian Signature

AUTHORIZATION AND ASSIGNMENT

In consideration of Alexander J. Carr, D.C., Yavapai Chiropractic Clinic, and/or Wellness Health Associates, P.C. providing care for me, I agree to the following:

1. Dr. Carr is authorized to release any information he deems appropriate concerning my physical condition to my insurance company, attorney or an adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to Dr. Carr of any sum I now or hereafter owe him by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, Dr. Carr for the charges made for services refuses to make such payment upon demand by Dr. Carr, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize Dr. Carr to prosecute said action either in my name as he sees fit and further authorize him to compromise, settle or otherwise resolve said claim as he sees fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, Dr. Carr will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts Dr. Carr does not collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I understand that the statute of limitations on collections and/or recovery in the State of Arizona is 6 years from date of treatment.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed Dr. Carr is paid in full.

X_____ Date _____
Patient/Guardian Signature

_____ Date _____
Staff Signature

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible)** by the Doctors of Chiropractic employed at Yavapai Chiropractic Clinics.

I understand that the Yavapai Chiropractic Clinic is a professionally owned, private practice of Alexander J. Carr, D.C., who is licensed by the State of Arizona Board of Chiropractic Examiners. I also understand that I will be examined and treated by Alexander J. Carr, D.C. or by other Doctors of Chiropractic employed at Yavapai Chiropractic Clinic.

The purpose of chiropractic services is to promote natural health and healing through the reduction of the vertebral subluxation complex (VSC or "restriction"). As with medical procedures, there are rare risks involved with manual therapy treatments. We believe that you should be aware of these risks no matter how remote. Manual therapy of the spine, in rare cases, has been associated with injury to neck arteries and/or intervertebral discs, causing neurological injury, stroke or death. These cases usually occur when there is a pre-existing condition. If you have any health conditions, please notify the chiropractic physician.

Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Appropriate examination will be performed on you to help identify any risks to manipulative therapy.

TO THE PATIENT
Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment by the doctors of the Yavapai Chiropractic Clinics. The chiropractic physician has explained the risks and benefits, and I accept the risk described and hereby consent to treatment.

_____
Patient Name (please print)

X_____ _____
Patient/Guardian Signature Date

**** PLEASE COMPLETE THE INFORMATION ON THE OPPOSITE SIDE OF THIS PAGE IF THE PATIENT IS A MINOR**

Yavapai Chiropractic Clinic
Alexander J. Carr, DC
142 N. Rush St.
Prescott, AZ. 86301
www.carrclinic.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on initial examination date and remains in effect until replacement of this notice.

I. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

II. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

III. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without you specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

Notice of Privacy Practices

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

1. **Notification:** Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

2. **Disaster Relief:** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

3. **Fundraising:** We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

4. **Research in Limited Circumstances:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

5. **Funeral Director, Coroner, and Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

6. **Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

7. **Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

8. **Public Health Activities:** As required by; law, we may disclose your medical information the public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

9. **Victims of Abuse, Neglect, or Domestic Violence:** We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

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10. **Workers Compensation:** We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

11. **Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

12. **Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and craves in emergencies.

IV. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $ .10 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to our office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Yavapai Chiropractic Clinic
Alexander J. Carr, DC
142 N. Rush St.
Prescott, AZ. 86301

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the **"Notice of Privacy Practices Act"** and I have been provided an opportunity to review it.

_____ Date of Birth _____
Name (Please Print)

X_____ Date _____
Patient/Guardian Signature

THE PRIVACY ACT REQUIRES THAT ALEXANDER J. CARR, D.C., YAVAPAI CHIROPRACTIC CLINIC, AND/OR WELLNESS HEALTH ASSOCIATES, P.C. HAVE YOUR CONSENT TO CONTACT YOU BY TELEPHONE, MAIL OR EMAIL. YOUR PRIVACY IS OUR GREATEST CONCERN. YOUR INFORMATION WILL ONLY BE USED BY THE ABOVE NAMED ENTITIES FOR THE PURPOSE OF PROVIDING YOU WITH INFORMATION ABOUT THEM OR CHIROPRACTIC SERVICES IN GENERAL AND NOTIFICATION OF MISSED OR RESCHEDULED APPOINTMENTS.

PLEASE NOTE THAT WE DO NOT SHARE, RENT OR SELL ANY PERSONAL INFORMATION WITH ANYONE. FOR MORE INFORMATION, PLEASE SEE OUR PRIVACY POLICY.

IF YOU AGREE TO THESE TERMS AS STATED ABOVE, PLEASE SIGN AND DATE BELOW.

X_____ Date _____
Patient/Guardian Signature

Yavapai Chiropractic Clinic
BILLING AND PAYMENT POLICY

1. **COPAYS AND SELF-PAY PAYMENTS ARE REQUIRED ON THE DATE THAT SERVICES ARE RENDERED.**
    A. Payment can be made with cash or check.
    B. Payment by credit card (Visa or MasterCard).
2. **IF YOU ARE UNABLE TO MAKE A PAYMENT ON THE DATE THAT SERVICES ARE RECEIVED**, the receptionist may have you fill out and sign a "Patient Payment Plan" form.
3. **IF YOU HAVE HEALTH INSURANCE THAT WILL COVER OUR SERVICES,** or if it has changed, please inform the receptionist at the time of your visit.
    A. As a participating provider to insurance, we will wait for reimbursement from your insurance company, if you have provided us with the necessary information. This must include the name of the insurance company, mailing address, plan number, group number, policyholder's name, etc. (found on the policy holder's insurance plan card).
    B. Charges are the responsibility of the patient from the date the services are rendered. If you have a deductible that must be met or if the services are not covered by your insurance, you are responsible for the payment. To guarantee fairness between those with insurance coverage and those paying at the time of service, we will charge you for first visit exams, periodic re-exams and the cost of the chiropractic manipulation only (see "Office Fees" form), less your copay, if already paid. This policy helps us to recover, at least partial compensation for our services to you, when insurance is inadequate.
4. **IF YOU ARE COVERED BY MEDICARE OR STATE INSURANCE (ACCCHS, MEDICAID, etc.):**
    A. Payment is required from you on the day of your visit for the services that are not covered by Medicare, etc. These services usually include x-rays, physiotherapy, orthopaedic supplies, and nutritional supplements.
    B. We will then submit a claim to Medicare for the services that are covered by Medicare. This usually includes charges for chiropractic manipulation only. However, we will also submit any charges for physiotherapy for denial, as some supplemental insurance companies will cover this charge with a Medicare denial notice.
    C. Once we have received an explanation of benefits (EOB) from Medicare and your supplemental insurance company (if you have one), we will bill you for the remaining balance for the chiropractic manipulation only.
5. **WE SEND INSURANCE BILLING STATEMENTS WEEKLY ON EVERY TUESDAY.**
6. **AN INTEREST CHARGE OF 1.25% PER MONTH (15% ANNUALLY) IS ASSESSED ON ALL ACCOUNTS THAT ARE OLDER THAN 60 DAYS.**
7. **WE WILL SEND PAST DUE ACCOUNTS NOTICES AT 60, 90, AND 120 DAYS.** If the account has not been paid in full or if payment arrangements have not been made 30 days after receipt of the third collection letter (120 days) your account will be turned over to a collections agent.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage PLEASE don't hesitate to ask us. We are here to help you.

Yavapai Chiropractic Clinic

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Fee Disclosure & Payment Policy

1. SPINAL ADJUSTMENTS:
   A. 1 – 2 spinal regions - $45.00
   B. 3 – 4 spinal regions - $55.00
   C. 5 spinal regions - $65.00
2. EXTRA SPINAL ADJUSTMENTS: $25.00 (Hand, Wrist, Knee, etc.)
3. MYOFASCIAL RELEASE: $10.00 (Deep Tissue Technique)
4. PHYSIOTHERAPY:
   A. Ultrasound - $35.00
   B. Electrical Muscle Stimulation - $25.00
   C. Hot/Cold Packs - $20.00
5. EXAMINATIONS:
   A. New Patient - $100.00 to $160.00
   B. Established Patient - $35.00 to $100.00
6. CONSULTATIONS (one-on-one time with the doctor): $50.00 to $120.00
   *charge is dependent on amount of time spent in consultation
7. AFTER HOURS SERVICES:
   A. Adjustments - $75.00
   B. Physiotherapy - $20.00 to $70.00
   C. House Calls - $100.00 (adjustment only) to $170.00 (physiotherapy)

****WELLNESS HEALTH ASSOCIATES, P.C. WILL PROVIDE INSURANCE BILLING SERVICES BY AR MED MEDICAL BILLING, AS A COURTESY TO YOU, OUR VALUED PATIENT. PLEASE REMEMBER THAT YOU ARE ULTIMATELY RESPONSIBLE FOR ANY CHARGES INCURRED IN THIS OFFICE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE AND/OR ANY OTHER BALANCES NOT PAID BY YOUR INSURANCE CARRIER. YOUR SIGNATURE ON THIS DOCUMENT INDICATES THAT YOU AGREE TO PAY FOR ANY OUTSTANDING BILLS INCURRED IN THIS OFFICE.**

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND OUR PATIENT FEES REASONABLE, WE EXPECT CASH PAYMENTS AND INSURANCE CO-PAYMENTS BEFORE EACH TREATMENT SESSION.

TO THE PATIENT
Please discuss any questions or problems with the front desk staff before signing this statement of policy.

I have read, and understand the foregoing.

_____
Patient Name (please print)

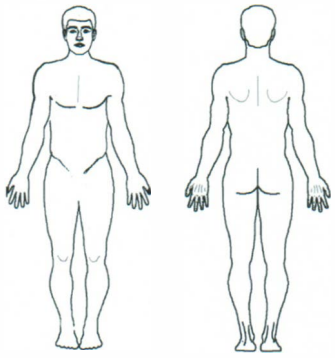
X_____ _____
Patient/Guardian Signature Date

American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/304-2746

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
Primary Care Physician Name: _____ PCP Phone: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain
☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began:

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) _____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
_____
_____
☐ Medications: _____
_____
_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____