

FINANCIAL POLICIES  
SAN FRANCISCO CHIROPRACTIC

1. **Payment is due at the time of service.** We accept cash, major credit cards, debit cards, travelers checks, and personal checks (with valid driver's license).

- The cash rate for the initial visit is \$75 and includes taking an initial history, spinal exam, and treatment.
- Follow up visits are \$55 - \$65 depending on whether or not you require physiotherapy or soft tissue work.

2. If you intend to use your health insurance, **coverage must be verified BEFORE you arrive to your appointment.** We can check your coverage for you if you allow one day, but ultimately it is your responsibility to know what your plan covers. If your insurance coverage is not verified prior to your arrival, you can pay out of pocket and we can print out a statement for you to submit to your insurance company to get reimbursed (upon your request). Optionally, if your treatment requires additional visits and it is later determined that you have some chiropractic coverage, your initial payment can be applied to your copays for those future visits.

3. Verification of insurance is not a guarantee of coverage. What this means is that your insurance plan may tell us/you that you have chiropractic coverage, but other factors (often found out after the fact) can influence reimbursement to our office such as incorrect information provided, deductibles not having been met, lapse in coverage, non-covered procedures, and medical necessity. You will be responsible for any balance left over after insurance payments are applied to your account, unless you made other arrangements with this office prior to your treatment.

4. If you are coming in for treatment related to a recent car accident, your primary insurance is your (or the driver of the car you were in) auto policy's Medical Payments (Med Pay) coverage, should it be available. Most group health plans will not cover medical treatment for auto accident-related injuries if Med Pay insurance is available. Med Pay covers 100% of necessary medical care, up to your policy limit. If this applies to you, please provide us with your auto policy's information including the claim number, date of accident, and claims adjustor's phone number and extension so that we can verify coverage. Please note that if you were not at fault, using your Med Pay coverage **will not** cause your insurance premiums to go up. You can confirm this yourself by calling the Department of Insurance help line at (800) 927-4357.

5. If you are coming in for treatment related to a car accident or other personal injury and were told that a 3<sup>rd</sup> party insurance (the at-fault party's liability insurance) will pay for your medical care, you still are required to pay at the time of service. This office does not bill 3<sup>rd</sup> party insurance. Once you pay, we can provide you with a statement of your account that you can use to get reimbursed by the 3<sup>rd</sup> party insurance.

On some occasions, at the doctor's discretion, we may agree to treat you on a personal injury lien, whereby you don't pay until your case settles, and your medical bills are subtracted from your award. This option requires you to be represented by a qualified personal injury attorney who meets our approval.

6. If your condition is a Workers Compensation case, pre-authorization is required. You will need to file a claim through your employer; then provide our office with the claim number, date of injury, and claim adjustor's name, phone number and extension. Once authorization is received, we will contact you.

*Please sign below to indicate that you have read, understand and agree to our Financial Policies:*

\_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT INTAKE FORM**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Date Injured (if applicable): \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Marital Status: M / S / D / W / SEP

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Street Address: \_\_\_\_\_

Employer City: \_\_\_\_\_ Employer State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

How did you hear about us?  Friend  Sign  Google  Yahoo  Yelp  Other: \_\_\_\_\_

Describe your main pain / symptoms for which you are seeking help: \_\_\_\_\_

Describe secondary health concerns: \_\_\_\_\_

INSURANCE INFO (skip if you provided a copy of your insurance benefits card)

Insurance Company: \_\_\_\_\_

Type of Insurance:  Group coverage  Workers Comp Claim  Auto Med Pay

Insurance Street Address: \_\_\_\_\_

Insurance City: \_\_\_\_\_ Insurance State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

Insurance Policy#: \_\_\_\_\_ Claim#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Name (if not same): \_\_\_\_\_

Insured's Street Address: \_\_\_\_\_

Insured's City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's ID: \_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_

Insured's Relationship to Patient:  spouse  dependent  guardian

CASE HISTORY:

How long have you had the condition for which you are seeking treatment? \_\_\_\_\_

List doctors you have seen for this condition: \_\_\_\_\_

Did your condition arise from a car accident? Y N. Date/Time of Accident: \_\_\_\_\_

Did your condition arise from your occupation? Y N. If Yes, did you report it? \_\_\_\_\_

What activities make your symptoms worse? \_\_\_\_\_

Your symptoms are:  getting worse  constant  come and go

Do you feel deep, unrelenting pain in your body at night which makes sleep difficult? Y N

List and date all prior significant injuries (fractures, dislocations, hospitalizations): \_\_\_\_\_

List any orthopedic implants you have (artificial joints, surgical rods/pins, etc.): \_\_\_\_\_

List any surgically fused vertebrae: \_\_\_\_\_

List medications that you are taking: \_\_\_\_\_

**Please sign here and complete back page:** \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**HEAD:**

- Headache
  - sinus (allergy)
  - entire head
  - back of head
  - forehead
  - temples
  - migraine
- Head feels heavy
- Loss of memory
- Light headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

**NECK:**

- Pain in neck
- Neck pain with movement:
  - Forward
  - Backward
  - Turn to left
  - Turn to right
  - Bend to left
  - Bend to right
- Pinch nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis

**SHOULDERS:**

- Pain in shoulder joint (R – L)
- Pain across shoulders
- Bursitis (R – L)
- Arthritis (R – L)
- Can't raise arm:
  - above shoulder level
  - above head
- Tension in shoulders
- Pinched nerve in shoulder (R – L)
- Muscle spasms in shoulders  
(type: \_\_\_\_\_)

**ARMS & HANDS:**

- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- "Pins & needles" feeling in arms
- Pins & needles feeling in fingers
- Numbness in arms: R – L
- Numbness in fingers: R – L
- Hand/fingers go to sleep
- Cold hands
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength
- Finger joints "lock" when opening hand

**MID-BACK:**

- Mid-back pain
- Location: \_\_\_\_\_
- Pain between shoulder blades
- Sharp stabbing pain
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

**CHEST:**

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange-peel texture of breast
- Irregular heartbeat

**ABDOMEN:**

- Nervous stomach
- Foods can't eat
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

**LOW BACK:**

- Low back pain
  - upper lumbar
  - lower lumbar
  - sacroiliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down/sleeping
  - walking
- Pain relieves when \_\_\_\_\_
- Slipped disc
- Low back feels out of place
- Muscle spasms
- Arthritis

**HIPS, LEGS & FEET**

- Pain in buttocks (R – L)
- Pain in hip joint (R – L)
- Pain down leg (R – L)
- Pain down both legs
- Knee pain
  - inner knee
  - outer knee
- Leg cramps
- Cramps in feet (R – L)
- Pins & Needles in legs (R – L)
- Numbness of leg (R – L)
- Numbness of feet (R – L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R – L)
- Swollen feet (R – L)

**WOMEN ONLY:**

- Menstrual pain
- Cramping
- Irregular periods
- Cycle: \_\_\_\_\_ days
- Birth control \_\_\_\_\_ (type)
- Hysterectomy
- Genital cancer
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

**MEN ONLY:**

- Frequent Urination
- Difficulty starting
- Night urination
- Prostate pain / swelling

**GENERAL:**

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep \_\_\_\_\_ hrs/ day
- Loss of sleep \_\_\_\_\_ hrs/night
- Recent loss of weight: \_\_\_\_\_ lbs.
- Recent weight gain: \_\_\_\_\_ lbs.
- Coffee \_\_\_\_\_ cups/day
- Cigarettes \_\_\_\_\_ /day
- Other: \_\_\_\_\_
- Diabetes
- Hypoglycemia

**DISEASES:**

- Check diseases you have had. Circle those which you currently have:
- Cancer (type: \_\_\_\_\_)
  - Diabetes Type: \_\_\_\_\_
  - Hypothyroidism
  - Heart disease
  - High blood pressure
  - Stroke
  - Epilepsy (Last seizure: \_\_\_\_\_)
  - Hepatitis (type: \_\_\_\_\_)
  - Tuberculosis
  - Venereal Disease
  - HIV+ (How long? \_\_\_\_\_)
  - AIDS (How long? \_\_\_\_\_)
  - Rheumatoid arthritis
  - Chicken pox
  - Measles
  - SARS
  - Multiple sclerosis
  - Parkinson's disease
  - Brain tumor
  - Glaucoma
  - Vertigo / Tinnitus
  - Other: \_\_\_\_\_

## Email Opt-In Form

Being located downtown, most of our patients schedule their office visits during short breaks in their work day. This may describe your situation as well. We respect your time and make every effort to ensure that you are seen upon your arrival, with minimal wait time.

In order to maintain this high level of punctuality, we frequently have to make appointment confirmations. We have found that **email communication** is the best way to accomplish this because it is much less intrusive than a phone call. There are additional benefits as well.

### With email, you can:

- Confirm your appointments without being interrupted by a phone call from our office.
- Schedule appointments from your office while referencing your personal calendar.
- Quickly reschedule if an unexpected meeting or other situation comes up.
- Ask the doctor a question about your treatment via email.
- Request administrative things ahead of time, like a copy of your statement.
- Receive helpful information pertaining to your care in the form of our monthly *Health Tips* newsletters, which contain practical information on spinal care, nutrition, ergonomics, and lifestyle factors that you can benefit from right away.

If you provide your email, you will be sent an informative introductory course that covers the basics of your treatment plan, including all the therapies used at our clinic. This helps to answer the most common questions people have about chiropractic care.

---

### Please check one:

Yes, I want to be able to communicate via email. My email address is (please provide an email address other than your work email):

(Print legibly) \_\_\_\_\_

I do not wish to provide my email and prefer to be contacted via phone.

If you checked "Yes," please use this email address to contact us:

**appointments@sf-chiro.com**

---

Signature

---

Date

**Privacy Statement:** We make every effort to safeguard your email address using the latest anti-hacking and firewall technology installed on our systems. We guarantee that your email will not be disclosed to anyone outside this office and will not be used beyond what is mentioned on this form.

## NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy.

At San Francisco Chiropractic, we are very careful to keep your health information secure and confidential. This new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice.

You have the right to see or receive a copy of any of your health information.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Dr. Perez.

### Acknowledgement

I have received a copy of San Francisco Chiropractic's Notice of Privacy Practices

Print Name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

If signing as a parent or guardian, please print the name of the patient.