

FINANCIAL POLICIES
SAN FRANCISCO CHIROPRACTIC

1. **Payment is due at the time of service.**

- The cost for the initial visit is \$49 and includes taking an initial history, spinal exam, and treatment.
- You will be recommended a course of care based on your exam findings. It is up to you to follow through with the doctor's prescription, but it will be a conservative estimate of what is necessary to completely resolve your condition.
- Follow-up visits are on a sliding fee schedule. Pay between \$25 and \$65 depending on what you can afford that day. This policy was created to allow individuals of different income levels and financial situations to receive care at our office. Although we do not require income verification, we ask that you be mindful of the reason we offer a sliding fee schedule and pay an amount commensurate to your financial ability. That being said, we will accept your desired payment, no questions asked. We want you to feel comfortable and welcomed.

2. **We accept cash only.** However, major credit cards (Visa, MasterCard, Amex) can be accepted if a minimum of six (6) visits are pre-paid.

3. **INSURANCE.** We are in-network for Aetna PPO / POS and Blue Shield of California. We also accept Auto Med Pay (for car accident related injuries).

4. We generally do not accept other insurance plans where the doctor is out of network, unless there is a Health Savings Account (HSA) associated with it that offers some coverage during the deductible period.

5. Even if we don't accept your insurance (for direct billing), we can provide you with a statement of your account that you can submit to your insurance company for reimbursement (\$5 processing fee, generated at the end of care).

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: _____

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 complaint/symptoms: _____

Date of first onset of these symptoms: _____

Describe any secondary health concerns: _____

CASE HISTORY:

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: _____

Have you ever had an X-ray or MRI in the last 5 years? Y N

INSURANCE

We accept a limited number of health insurance plans. If you want us to check yours, please fax the front and back of your insurance card to (415) 627-9121 along with this form (filled out).

EMAIL OPT – IN

We offer periodic health info to our patients in an email newsletter or blog post format. Topics include exercise and stretching, nutrition, proper posture and ergonomics. The purpose is to foster healthy living habits and improve your results. If you would like to join our list (highly recommended) please provide your email here: _____

(Your email will be closely guarded and never sold to any third party).

Sign here and complete back page: _____

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/ Hypertension
 - 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: _____

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.