



## WELCOME TO WHOLE CHIROPRACTIC HEALTHCARE, LLC!

### 1 About You

Full name \_\_\_\_\_ Male  Female   
 What do you prefer to be called? \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_\_\_ Date of birth \_\_\_\_\_ SSN \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs  
 Home address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Employer name \_\_\_\_\_ How long worked? \_\_\_\_\_  
 Occupation \_\_\_\_\_ Work phone \_\_\_\_\_  
 Marital status    Single     Married     Divorced     Separated     Widowed   
 Spouse's/partner's name \_\_\_\_\_

### 2 In Case of Emergency

Whom should we contact? \_\_\_\_\_ Relation to you \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work/cell phone \_\_\_\_\_

### 3 Reason for Visit *(please answer each question as thoroughly as possible)*

The reason for this visit is    Work     Sports     Auto accident     Trauma     Chronic   
 Please explain \_\_\_\_\_

Describe the pain and its location \_\_\_\_\_

Does anything relieve your pain? Please explain \_\_\_\_\_

Mark an **X** on the line below to rate the current level of pain/symptoms between 0 and 10

(NO PAIN) 0 \_\_\_\_\_ 10 (WORST PAIN)

Date this condition began \_\_\_\_\_

Is the condition: Getting worse     Staying the same     Coming and going  ?

Any radiating/shooting pain involved? Yes     No     If Yes, where? \_\_\_\_\_

Is the condition interfering with your: Work  Sleep  Tying shoes  Eating  Changing clothes

Bathroom habits  Exercise  Sitting  Standing  Lying down  Walking  Other  \_\_\_\_\_?

List older injuries/symptoms in this same area \_\_\_\_\_

Have you ever been treated by a chiropractor in the past?    Yes     No

If Yes, please explain: \_\_\_\_\_

Has a medical physician treated you for this condition?    Yes     No

If so, Doctor's name \_\_\_\_\_

May we contact this doctor to discuss your care?    Yes     No

What was the treatment? \_\_\_\_\_

# 4 Health History

Please list all medicines you are currently taking (prescription and over-the-counter) \_\_\_\_\_

List all vitamins/supplements you are currently taking \_\_\_\_\_

List any surgeries or serious illnesses/injuries (with dates) you have or ever had \_\_\_\_\_

Past serious accidents, with dates \_\_\_\_\_

Please list anything you may be allergic to \_\_\_\_\_

Do you smoke? Yes  No  If Yes, how much? \_\_\_\_\_ No. of years? \_\_\_\_\_

Do you drink alcohol? Yes  No  If Yes, how many drinks/week? \_\_\_\_\_

Do you drink caffeine? Yes  No  If Yes, how many drinks/day? \_\_\_ Coffee/Tea/Soda/Other \_\_\_\_\_

Do you drink water daily? Yes  No  If Yes, how many glasses (8 oz)/day? \_\_\_\_\_

Are you currently wearing: Arch supports  Heel lifts  Sole lifts  Inner soles

How many years old is your mattress? \_\_\_\_\_ Is it comfortable? Yes  No

Type of mattress "Normal"  Tempurpedic  "Sleep Number"  Other  \_\_\_\_\_

What type of pillow do you use? Normal/polyfill  Feather  Orthopedic/contour

How many years old is your pillow? \_\_\_\_\_

**For Women** Are you taking birth control? Yes  No  If yes, what type? \_\_\_\_\_

Are you pregnant? Yes  No  If Yes, how many weeks? \_\_\_\_\_ Nursing? Yes  No

# 5 Family Health History

*If you or members of your family have experienced any of these health issues, indicate "yes" by checking the appropriate box. We need to know your complete health history to give you the most appropriate treatment.*

Condition	Self	Spouse	Mother	Father	Sibling	Child	Child
Abdominal problems/colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm/hand cramps/weakness/numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/emphysema/breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (upper, mid, lower)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis/joints ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems/diarrhea/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Earaches/hearing problems/tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems/light-sensitivity/glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia/pre-menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## PRIVACY NOTICE (HIPAA)

*This notice describes how medical information about you may be used and disclosed, and how you can receive access to this information. Please review it carefully and thoroughly.*

In the course of your care as a patient at Whole Chiropractic Healthcare, LLC, we may use or disclose personal and health-related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment, or care.*

*Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, HMO, PPO, or your employer, if they are or may be responsible for the payment of your services.*

*Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health-related information that may be of interest to you.*

You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you are not at home/work to receive an appointment reminder, a message that does not contain personal information about you or your treatment may be left on your answering machine/voicemail, or with office staff. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes.

Under federal law, Whole Chiropractic Healthcare, LLC, is also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing healthcare services to you based on the orders of another healthcare provider.*

*If we provide healthcare services to you in an emergency.*

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.*

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.*

*If we are ordered by the courts or another similar agency.*

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

Whole Chiropractic Healthcare, LLC, normally provides information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your healthcare or regarding the status of your account. Our office will also periodically send out personal mail (birthday cards, thank you notes, etc.). If you would like to receive this information at an address other than your home or would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date the record was created, or as long as the information remains in our files (whichever is longer). In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided to us in writing. Please note: Whole Chiropractic Healthcare, LLC, may not be able to provide a copy immediately—some of your healthcare information may be stored in another secure location or not easily accessible.

Whole Chiropractic Healthcare, LLC, is required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

*If you would like further information, have a question, or have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, please contact:*

Laurie C. Hyland Robertson  
Whole Chiropractic Healthcare, LLC  
1202 Annapolis Rd., Suite I, 2nd Fl.  
Odenton, MD 21113-1387

This privacy notice is effective as of May 1, 2009. This privacy notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created.

My signature below acknowledges that I have read and understood both pages of the Whole Chiropractic Healthcare, LLC, Privacy Notice, and that I was offered a copy of the notice.

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Patient Name (please print)

Patient/Guardian Signature

Date

Dr. Robertson and Whole Chiropractic periodically send out an e-mail newsletter offering health and wellness tips and resources. (Although we may use a secure mailing service such as Constant Contact, we NEVER share our e-mail lists with any third parties.)

**Please check here if you do NOT want to receive our newsletter**

## FINANCIAL POLICY

*We are providing you with this financial policy in writing to clarify any questions of payment that may arise in the future.*

### **Updating Personal Information**

You need to update your personal information file every time your information changes so we can keep your data as current as possible. We also need to be able to keep in contact with you in the event that the office hours change, the office moves to another location, adds another provider, or makes any other changes.

### **Insurance Assignment**

At Whole Chiropractic Healthcare, LLC, (WCH), we offer the option of insurance assignment strictly as a courtesy to our patients. As such, our patients must understand and agree to the following:

1. You are considered a cash patient until you bring in your insurance card and this office both qualifies and accepts your insurance coverage.
2. You are ultimately responsible for full payment for any and all services rendered, except when health insurance contract rates apply or when a signed Hardship Agreement with WCH is already on file.
3. Any co-payments and/or deductibles must be paid in full at the time of service. Estimated co-insurance must be paid at the time of service, or you may make arrangements with WCH to deposit a co-insurance "retainer" with the office. Any remaining co-insurance amount must be paid when WCH receives the explanation of benefits (EOB) from the insurer; if you paid more than the amount of the co-insurance, we will apply a credit to your account. If your course of care is complete, WCH will issue a reimbursement within 30 days of receipt of the final EOB.
4. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim. As such, after 90 days of non-payment by the carrier you are solely responsible for payment in full for any outstanding balance. If after 90 days, WCH is paid by your insurance carrier any claim that you had previously covered, you will be reimbursed the balance, or you may apply the balance to future charges.
5. In the event that you discontinue your program of care prior to the doctor's recommendation, you are responsible for payment in full of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued.

We ask that you sign this form at the bottom as acknowledgment that our office has explained the policy to you, and that you understand it and accept full financial responsibility for all services rendered to you at WCH.

### **Forms of Payment Accepted**

WCH accepts cash, check, Visa, Mastercard, and Discover. Checks returned for any reason will be re-presented, via ReSubmitIt or another service, to your bank account for collection of the amount of the check, plus any applicable fees as permitted by state law. If WCH is charged a returned-check fee by its bank, that fee will also be passed on to the patient. If these charges, plus the original amount, are not paid within 90 days of the original billing date, the account may be forwarded to a collection agency.

### **Medicare Policy**

Dr. Hyland Robertson is a non-participating provider who does not accept assignment for Medicare Part B. This means that the cost for all services rendered at WCH, as well as any Medicare co-insurance, must be paid by you on the date the service is rendered (provided you have signed the Advanced Beneficiary Notice [ABN] prior to the service being rendered), regardless of whether Medicare will reimburse you, the patient, at a later date. As a courtesy, WCH will bill Medicare and any secondary insurance (electronically when possible); patients must agree that neither they nor their agents will bill Medicare for services rendered at WCH.

Medicare will typically reimburse patients for 80% of the covered services once claims are processed. Any non-covered services will then be billed to you (or to your secondary health insurance, if applicable), unless prior arrangements have been made.

**For Patients Without Insurance Coverage**

At WCH, we believe that a clear understanding of our financial policy will allow everyone to better concentrate on the main issue, regaining and maintaining your health. Therefore, it is agreed between us that payment will be made in full at the time services are rendered.

**Delinquent Accounts**

In the event that a patient stops making payment on his/her outstanding balance for longer than 45 days, he/she will be considered as having a delinquent account and may be dismissed from the practice. These patients will be given sufficient opportunity to find another provider. Before patients with delinquent accounts will be allowed to return for care, they must pay their entire balance in full. Patients who have had delinquent accounts in the past may be required to pay for future visits "up-front," in cash. Patients with outstanding balances may have their account(s) forwarded to a collection agency after 90 days of non-payment.

**Please see our separate policies for auto accident and worker's compensation patients.**

We welcome the opportunity to discuss any aspect of our financial policy. Please contact Laurie Hyland Robertson (410. 305.1331 or LaurieHR@wholechiro.com) if you have any questions.

*I understand this financial policy fully, and hereby agree that if I should terminate care for any reason, my outstanding balance becomes due and payable immediately. I also understand that my account must be kept current in order for WCH services to be continued. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I also authorize WCH to release any of my information required to process insurance claims.*

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Patient Name (please print) \_\_\_\_\_ Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACCOUNT INFORMATION**

**Who is ultimately responsible for this account?**

Full name \_\_\_\_\_ Relation to you \_\_\_\_\_  
Billing address \_\_\_\_\_ Work/cell phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



## LATE CANCELLATION AND NO-SHOW POLICY

Because Whole Chiropractic Healthcare, LLC (WCH), schedules a limited number of appointments each week, we need to be able to depend on these appointments to successfully operate our practice. Therefore, WCH has established this following policy for missed appointments.

For any appointment that is cancelled with less than 24 hours' notice, you will be charged a cancellation fee of \$20. This fee is not billable to your insurance, and must be paid by you directly. (WCH may offer a grace period at our discretion.)

We realize that sometimes emergencies come up and appointments cannot be kept. The purpose of this policy, however, is to allow us to reserve your slot and enable us to schedule a reasonable number of patients each week. Therefore, even if there is an excellent reason why 24 hours' notice was not possible (such as illness, car breakdown, etc.), the cancellation fee will still have to be paid.

If you are ill, note that chiropractic treatment may in many cases help you to feel better and speed the healing process (regardless of the nature of the illness). The staff of WCH take care to maintain healthy immune systems and are generally not concerned with the possibility of contracting communicable diseases; we also always practice "universal safety precautions" to minimize the spread of illness among patients. Therefore, ill patients are asked to keep their scheduled appointments if possible.

The \$20 fee will also apply even if the appointment is rescheduled for later in the same week. The reason for this is because without 24 hours' notice, we will be unable to fill the earlier time slot.

The only exception to this policy is inclement weather. If driving conditions are bad, and you do not feel safe to drive, please call WCH. If you call and we confirm that the clinic session has been cancelled due to inclement weather, the \$20 fee will be waived. Strict enforcement of this policy will allow WCH to continue to deliver the high-quality treatment you deserve.

Repeated late cancellations and appointment no-shows may result in dismissal from the practice. In that event, WCH will no longer be able to provide you with care. You will be notified by certified mail and given adequate time to find a new provider.

Your signature below verifies that you have been informed of this office policy.

Thank you for your cooperation!

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Patient Name (please print)

Patient/Guardian Signature

Date