WHOLE CHIROPRACTIC HEALTHCARE

Thomas K. Hyland Robertson, D.C.
1202 Annapolis Rd., Suite I ■ Odenton, MD 21113
410.305.1331 ■ www.WholeChiro.com

1 About You

Full name _____ Legal Sex: Male ❑ Female ❑ Date _____
What is/are your nickname and/or pronouns?_____
Age _____ Date of birth _____ SSN _____
Height _____ Weight_____lbs BMI_____ last BP_____R/L arm
Home address _____
City _____ State _____ Zip _____
Mobile phone _____ Home phone _____ (same)
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: Nutrition ❑ 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: _____

Have other providers treated you for this condition? Yes ❑ No ❑
If so, Provider's name(s) and phone number(s)_____
What was the treatment? _____
May we contact this(ese) doctor(s) to discuss your care? Yes ❑ No ❑

4 Health History

Please list all <u>medicines</u> you are currently taking (prescription and over-the-counter/OTC) _____

List all vitamins/supplements you are currently taking _____

_____

List ALL surgeries or serious illnesses/injuries (with dates) you have or ever had (if you need more space, please use the lines at the end of this form)_____

_____

_____

List past injuries and/or accidents, with dates for serious incidents_____

_____

_____

Please list anything you may be allergic to _____

_____

Do you smoke/vape or use tobacco? Yes ❑ No ❑ How much? _____ No. of years? _____
Have you ever smoked or used tobacco? Yes ❑ No ❑ 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 ❑
For Men Date of last prostate exam? _____

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	❑	❑	❑	❑	❑	❑	❑
Arthritis/rheumatoid	❑	❑	❑	❑	❑	❑	❑
Artificial valves	❑	❑	❑	❑	❑	❑	❑
Arm/hand cramps/weakness/numbness	❑	❑	❑	❑	❑	❑	❑
Asthma/emphysema/breathing problems	❑	❑	❑	❑	❑	❑	❑
Atherosclerosis	❑	❑	❑	❑	❑	❑	❑
Back pain (upper, mid, lower)	❑	❑	❑	❑	❑	❑	❑
Balance problems	❑	❑	❑	❑	❑	❑	❑
Bladder/urination pain/difficulty/incontinence	❑	❑	❑	❑	❑	❑	❑
Cancer/chemotherapy	❑	❑	❑	❑	❑	❑	❑
Chest pain/heart attack	❑	❑	❑	❑	❑	❑	❑
Congenital heart defect	❑	❑	❑	❑	❑	❑	❑
Depression/psychiatric problems	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Digestive problems/diarrhea/heartburn	❑	❑	❑	❑	❑	❑	❑
Dizziness	❑	❑	❑	❑	❑	❑	❑
Earaches/hearing problems/tinnitus	❑	❑	❑	❑	❑	❑	❑
Eye problems/light-sensitivity/glaucoma	❑	❑	❑	❑	❑	❑	❑
Fainting/seizures/epilepsy	❑	❑	❑	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑	❑	❑	❑
Fibromyalgia/pre-menopause	❑	❑	❑	❑	❑	❑	❑
Frequent colds	❑	❑	❑	❑	❑	❑	❑

Condition (cont. from previous page)	SELF	Spouse	Mother	Father	Sibling	Child	Child
Gall bladder problems	❑	❑	❑	❑	❑	❑	❑
Heart murmur	❑	❑	❑	❑	❑	❑	❑
Heart surgery/pacemaker	❑	❑	❑	❑	❑	❑	❑
Hemorrhoids	❑	❑	❑	❑	❑	❑	❑
Hepatitis/liver problems	❑	❑	❑	❑	❑	❑	❑
Hernia (stomach or groin)	❑	❑	❑	❑	❑	❑	❑
High/low blood pressure	❑	❑	❑	❑	❑	❑	❑
HIV+/AIDS	❑	❑	❑	❑	❑	❑	❑
Impotence	❑	❑	❑	❑	❑	❑	❑
Kidney problems	❑	❑	❑	❑	❑	❑	❑
Leg/foot cramps/weakness/numbness	❑	❑	❑	❑	❑	❑	❑
Memory problems/Alzheimer's	❑	❑	❑	❑	❑	❑	❑
Menstrual disorders/menopause	❑	❑	❑	❑	❑	❑	❑
Migraine or frequent headaches	❑	❑	❑	❑	❑	❑	❑
Mitral valve prolapse	❑	❑	❑	❑	❑	❑	❑
Muscle spasms/disease	❑	❑	❑	❑	❑	❑	❑
Neck/shoulder pain/problems	❑	❑	❑	❑	❑	❑	❑
Night sweats	❑	❑	❑	❑	❑	❑	❑
Rheumatic fever	❑	❑	❑	❑	❑	❑	❑
Sinus problems/allergies	❑	❑	❑	❑	❑	❑	❑
Skin disorders/shingles	❑	❑	❑	❑	❑	❑	❑
Sleeping problems	❑	❑	❑	❑	❑	❑	❑
Stomach disorders/ulcers/heartburn	❑	❑	❑	❑	❑	❑	❑
Stress/tension/irritability	❑	❑	❑	❑	❑	❑	❑
Stroke/brain damage	❑	❑	❑	❑	❑	❑	❑
Throat problems/tonsillitis	❑	❑	❑	❑	❑	❑	❑
Thyroid disorder (hypo- or hyper-)	❑	❑	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑	❑	❑

Any other condition(s) not listed above _____

_____

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- I authorize the staff of Whole Chiropractic Healthcare to perform any services needed during diagnosis and care, including examination.
- I understand the above information and guarantee that this form was completed correctly to the best of my knowledge. I know that it is my responsibility to inform this office of any changes in my medical status.

Patient Name (please print) **Patient/Guardian Signature** **Date**

We invite you to discuss with us any questions regarding our services.

How did you hear about us?

(below for doctor's use)

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WHOLE CHIROPRACTIC HEALTHCARE

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2013; Updated November 1, 2019

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

Whole Chiropractic Healthcare, LLC (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals, and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other healthcare providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another healthcare provider, we would, as part of the referral process, share PHI about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the healthcare services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company, parties working on behalf of your insurance company, or applicable government programs with information about your condition and the healthcare you need to receive prior approval or to determine whether your plan will cover the services.

Healthcare Operations – We may use and disclose your PHI for our own healthcare operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality healthcare. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders – We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief – We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend, or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will

appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your healthcare.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury, or disability
- To report births or deaths
- To report child, elder, or dependent-adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is a) required by law, b) agreed to by you, c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure, or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's healthcare system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury, or administrative order, warrant, or subpoena
- To identify or locate a suspect, fugitive, material witness, or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime, or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that identifies who you are, we will ask for your permission.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will NOT use or disclose your PHI for marketing purposes for which we have accepted payment. However, we may contact you with information about products, services, or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will NOT sell your PHI.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment, or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket, and we will abide by that request unless we are legally obligated to disclose the information.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both, and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing, or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy, or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment for healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; and disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave SW, Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Laurie C. Hyland Robertson
Address: 1202 Annapolis Rd, Suite i, Odenton, MD 21113
Telephone No.: 410.305.1331

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient Name (please print) Patient/Guardian Signature Date

We want to make sure you want to hear from us! 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 ☐

WHOLE CHIROPRACTIC HEALTHCARE

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 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, American Express, 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 he is unable to provide services for patients who have Medicare as an insurer. He *may* be able to provide wellness or maintenance services, or nutritional counseling, but these are services that cannot be billed to any insurance.

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 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 the office manager (410.305.1331 or officemgr@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.

Patient Name (please print) Patient/Guardian Signature Date

ACCOUNT INFORMATION

Please indicate the person ultimately financially responsible for this account, <u>if that person is not yourself.</u>

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

WHOLE CHIROPRACTIC HEALTHCARE

LATE CANCELLATION AND MISSED VISIT POLICY

Because Whole Chiropractic Healthcare schedules a limited number of appointments each week, we need to be able to depend on these appointments to successfully operate our practice. We have therefore established the following policy for missed appointments.

Please arrive on time. Although we will always do our best to see you on the day you're scheduled, we cannot extend your appointment due to lateness, as the doctor is on a set schedule. _____ **(Initials)**

Whole Chiropractic requires 24 hours' notice of your cancellation. You will be responsible for the following fees if less than 24 hours' notice is given.

- 1st Late Cancellation/Missed Visit—no charge. We understand that emergencies come up!
- 2nd Late Cancellation/Missed Visit—$25
- 3rd and all subsequent Late Cancellations/Missed Visits—$55

_____ **(Initials)**

Missed-appointment fees are not billable to your insurance, and must be paid by you directly. Payment can be made in the form of cash, check, or credit card.

Repeated late cancellations and missed visits may result in dismissal from the practice. In that event, Whole Chiropractic 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.

We appreciate your understanding.

Patient Name (please print)	Patient/Guardian Signature	Date

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