1512 Santa Fe Dr, Ste 103
Weatherford, TX 76086
817-594-3434

Roberts chiropractic

Today's Date_____

Referred By_____

Legal First Name_____ Nick Name_____

Last Name_____ Date of Birth_____

Address_____ APT_____

City_____ State_____ Zip Code_____ Gender M☐ F☐

Marital Status_____ Spouse Name_____

SSN_____ Email_____

Phone Number_____ Cell Phone Number_____

Appointment Reminders will be emailed or texted to you. Normal fees apply. Initial_____

Cell Provider_____

Occupation_____ Employer_____

Employer Address_____

City_____ State_____Zip Code_____ Phone Number_____

Please check the following

☐ Self-Pay ☐ Personal Injury

☐ Insurance: Policy Holder: Patient ☐ Spouse/Parent

Insured's Name_____

Insured's Occupation_____ Employer_____

Employer Address_____

City_____ State_____Zip Code_____ Phone Number_____

Emergency Contact Name_____

Phone Number_____ Relationship to Patient_____

"I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any claims. I request payment of this claim and, if the payer accepts assignment, I authorize payment directly to the physician or supplier for the services described."

Patient or Authorized Signature_____ Date_____

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

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TO: Dr. Roberts/Roberts Chiropractic & Staff

Patient Name: _____

REFERENCE: Photo Identification, Storage, and/or Usage

1. I hereby give permission to have my photograph stored on your patient records electronic system to assist with proper record identification

Patient or Authorized Signature _____ DATE _____

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WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

5. Unless indicated by the doctor, you may return to work/school after your appointment.

6. If a sudden movement causes sharp or severe pain, or if you experience swelling, contact the clinic at 817-594-3434. After hours, contact Dr. Roberts at 972-977-6365.

I have read and understand the instructions given for my follow-up care.

_____ _____

Patient's Signature Date

Roberts chiropractic

1512 SANTA FE DRIVE, SUITE 103

WEATHERFORD, TX 76086

817-594-3434 817-594-7676

CREDIT GUARANTEE FOR PERSONAL BALANCES

Patients are personally responsible for payment of services. It is our policy to work with the patient to receive payments for service. We accept insurance and payment plans. Consult the front desk for payment options.

1. **Payment plan:** Patients who do not have ins.
2. urance, or insurance that does not cover chiropractic care, may make payments arranged in advanced with the front office.

3. **Insurance:** Our office will file your insurance on your behalf. However, you are responsible for the fee for services provided to you. Note that insurance DOES NOT PAY until your full deductible has been met. Only after your deductible has been met will a co-pay for services be accepted. Your co-pay with insurance payments must meet the minimum payment for services required by this office. (See Insurance ABN for more information or ask the front office.) Dr. Roberts requires that a Credit Guarantee be on file for your personal balances. This card WILL NOT BE CHARGED without your prior knowledge and agreement.

Credit/Debit Card Type: Amex ◯ Visa ◯ MC ◯ Discover ◯

Cardholder Name: _____

Card Number:_____Exp. Date: _____ CVV: _____

TERMS AGREED UPON:

_____

_____

_____

_____

_____ _____

Patient's Printed Name Cardholder Signature

_____ _____

Agreement Date Approved By

Revised: 1/15/2019

"Bending Our Backs, To Straighten Yours"

Roberts Chiropractic
1512 Santa Fe Ste 103
Weatherford, TX 76086
Phone: 817-594-3434 Fax: 817-594-7676

Patient Name:

(INSURANCE) Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: *Insurance does not pay until you have met your deductible. Additionally, Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Insurance may not pay for, or will only partially pay, for the service(s) below.*

Service	Reason Insurance May Not Pay:	Minimum Cost
New Patient Exams	May not be considered medically necessary	$75-$250
Established Patient ReExams		$50-$125
XRays	Contracted amount by your insurance company	$75-$110 per series
Spinal Adjustment	may be less than the minimum required	$50-$65
Extremity Adjustment (ribs,arms,legs)	amount for the services rendered. (This office	$10
Therapies (Heat/Cold pack & EMS)	has no control over how your deductible is	$10 each session
Stretching and/or Exercises	applied, or how much of what you pay is	$35 per 15 Min.
Cold Laser	applied to your deductible.)	$10 per 15 Min.
Percussor		$35 per 15 Min.
Decompression	{Example:	$75 per session
Nutritional Counseling	Exam $75 – Patient pays $75 - Insurance pays $15. Patient is reimbursed $15. (Insurance will only apply $15 toward your deductible.)}	$50-$100 per session

WHAT YOU NEED TO DO NOW:

- **Read this notice, so you can make an informed decision about your care.**
- **Ask us any questions that you may have after you finish reading.**
- Choose an option below about whether to receive the service listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Insurance cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the service listed above. You may ask to be paid now, but I also want Insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if Insurance doesn't pay, or only partially pays, I am responsible for the balance of the minimum payment, but **I can appeal to Insurance** by following the directions on the EOB. If Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the service listed above, but do not bill Insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Insurance is not billed**.

☐ **OPTION 3.** I don't want the service listed above even though the Doctor may deem it to be necessary to my care. I understand with this choice I am **not** responsible for payment and **I cannot appeal to see if Insurance would pay.**

Additional Information:

This notice gives our opinion, not an official Insurance decision.

Signing below means that you have received and understand this notice. You may also receive a copy.

Signature:	**Date:**

Roberts Chiropractic

"Bending Our Backs, to Straighten Yours"

GENERAL/FINANCIAL POLICY

Welcome to Roberts Chiropractic. We strive to provide you with excellent Chiropractic care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.
- If you are not up to date on your payment(s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us 24 hours before your appointment so that we may offer that time to another patient.
- There is a $75.00 charge for no call, no shows.
- A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.
- Cellphones must be turned off or on vibrate while in the office.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Your deductible must be met prior to making co-pays.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance. You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits (EOB) from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT**, please be advised that Medicare **only covers** 80% of Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility. Medicare DOES NOT cover maintenance adjustments.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

Printed Name	Signature of Patient	Date

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below, I hereby give my consent for Roberts Chiropractic to release my medical records to:

Name of Family Member/Friend	Signature of Patient/Legal Guardian	Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for *Roberts Chiropractic* to examine, and if needed, treat my minor child.

Print child's name here

Printed Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date