



NEW PATIENT PACKET

Thank you for choosing Health First Rehab, INC for your healthcare needs. Call us directly at 508-362-2945 or Dr. Josh's cell 508-221-1169 if you have not already scheduled your initial evaluation appointment.

Print and complete all forms (scroll down to view) to the best of your ability. If you have any questions, please leave that section blank and we can assist you during your initial visit with us:

- 1. New Patient & Insurance Form**
- 2. Patient Pain Form**
- 3. Office Policy**
- 4. Informed Consent**
- 5. Privacy Notice Acknowledgement**

There will likely be additional forms to fill out on your first visit depending on your particular circumstance. We will be glad to assist you in expediting the proper forms.

Thanks again for choosing Health First Rehab, INC. Your trust and confidence is greatly appreciated.

Patient and Insurance Information

Name: _____ Date: / /

Address: _____

Town: _____ State: _____ ZIP: _____

Home Phone: _____ Cell #: _____ Work #: _____

E-mail address: _____

Date of Birth: / / Social Security # - -

Marital Status: M S Name of Spouse: _____

Referred By: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Employer: _____ Occupation: _____

Address: _____

Town: _____ State: _____ ZIP: _____

Health Insurance Info: Please Give Insurance Card to Receptionist to Copy None

Insurance Carrier: _____ Phone: _____

Plan Name: _____

Address: _____ State: _____

Policy #: _____ Group #: _____

Patient Relationship to the insured: Self Spouse Child Other:

If you are covered under another persons insurance.... Please complete

Name of Insured: _____

Address of insured: _____

Phone of insured: _____ Insured's Birth date: / /

Insured's Employer: _____ Phone: _____

Employer Address: _____

Auto Accident /Worker's Compensation Date of Accident: / /

Carrier: _____ Policy Number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Claim # _____ Contact Person/Adjuster: _____

Note: All patients must review and sign our office policy regarding insurance billing and patient responsibilities prior to treatment.

Office Policies- Health First Rehab, Inc.

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies.

Prompt Cash Payment

Effective January 1, 2007, Prompt Cash Payment will be \$50.00 per visit. This fee includes massage therapy and additional modalities used in conjunction with your adjustment.

Massage Therapy Non-Covered Service Waiver

Massage therapy services are offered during each treatment visit. However, massage therapy services performed by a licensed massage therapist in this office are not a covered benefit under your current health plan, as these procedures are not performed directly by a participating physician/provider. If you choose to undergo massage therapy as part of your treatment, you will be billed a fee of \$5.00 per visit for this service.

Patient Payment Policy

Payment for all services, including copays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than 45 days, there will be a finance charge of 5% per month.** In the event you do not have insurance coverage, we are here to serve everyone in this community. Therefore, part of this service means making sure that money is never a barrier to good healthcare. We offer various cash payment plans and are willing to work out a program that is appropriate to your situation. These flexible plans will be set up on a per patient basis after discussing your individual financial needs.

Appointment Cancellation Policy

In order to better serve our patients, we ask that you cancel your appointment with at least **24 hours** notice. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could have been used to help someone else. Health First Rehab, Inc. reserves the right to charge \$30.00 for the missed visit if this policy is abused. This amount is not covered by any insurance plan and will be the patient's responsibility. Thank you for your consideration and helping us help others.

Emergency or After Hours Calls

If you require emergency attention outside of the regular office hours, please contact Dr. Josh directly at **(508) 221-1169**.

Our Policy on Health Insurance

We will be happy to file your primary insurance claim for you and do everything we can to insure you receive proper reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment.

I have read and received a copy of the Health First Rehab, Inc. Policies and will honor them:

Print Name

Patient Signature

Date

Health First Chiropractic

**477 Route 6A, Suite 3
Yarmouthport, MA 02675**

Phone: 508-362-2945
Fax: 508-362-2946

**106 Falmouth Road
Mashpee, MA 02649**

Phone: 508-539-6872
Fax: 508-539-6873

Patient Name: _____

Please read and sign the following consents, releases and agreements.

- 1. CONSENT TO ROUTINE CLINIC SERVICES:** I consent to the services being rendered during this visit on an outpatient basis by the doctor of chiropractic named above and or any other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back up for the doctor of chiropractic named above. I understand that I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic manipulative therapy, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
- 2. AUTHORIZATION FOR DIRECT PAYMENT OF INSURANCE BENEFITS TO THE HEALTHCARE PROVIDER AND CLINCS:** I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.
- 3. MEDICARE CERTIFICATION AND PAYMENT REQUEST:** I am applying for payment under Medicare or Medicaid. I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services to the provider(s) or organization furnishing the services or authorize them to submit a claim to Medicare on my behalf.
- 4. AUTHORIZATION TO RELEASE INFORMATION:** In obtaining payment for services, I authorize my healthcare provider(s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.
- 5. PROTECTED DIAGNOSIS:** If my medical record contains information about drug or alcohol diagnosis or treatment of HIV testing, I specifically authorize the release of this information for billing purposes ONLY. I understand that the specific time period during which release of this information may occur will be 180 days after I sign this consent form. It may be revoked at any time except to the extent that action has been taken in reliance on the consent.

I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

1. _____
Signature of Patient Date

2. _____
Signature of Representative Date Relationship to Patient

Health First Chiropractic

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Yarmouthport, MA 02675

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Fax: 508-362-2946

106 Falmouth Road
Mashpee, MA 02649

Phone: 508-539-6872
Fax: 508-539-6873

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are required to make available to you a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that a copy of the *Notice of Privacy Practices for Protected Health Information* for this office has been made available to me. I understand that I will be given a copy of this document upon my request.

Patient Name Printed

Date

Patient Signature

Patient Representative Printed

Date

Patient Representative Signature

Description of representative's authority to act for patient