DARON HALLE CHIROPRACTIC

Dr. Daron G. Halle • Chiropractic Physician
8877 West Union Hills Drive, Suite 300 • Peoria, AZ 85382 • (P) 623.583.8190 • (F) 623.583.8788

Welcome to our office! *Thank you for choosing us as your chiropractic provider. Please complete the following information.*

PATIENT INFORMATION

I am a/an: ☐ New patient ☐ Existing patient/providing updated information

Legal name: _____ SSN: _____ Preferred name: _____

Birth date: _____ Age: _____ ☐ Male ☐ Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

Are you: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Prefer not to indicate

Health complaints/reasons for consulting this office: _____

Is this due to a: ☐ Work-related injury ☐ Vehicle accident/injury

Whom may we thank for referring you? _____

Please indicate whom we could contact in case of an emergency:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

FINANCIAL INFORMATION

Legal name of person responsible for this account: _____ Relationship to patient: _____

SSN: _____ ☐ Male ☐ Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

INSURANCE INFORMATION

I choose not to provide or use my insurance ☐

Legal name of insured: _____ Relationship to patient: _____

Insured's birth date: _____ SSN or Member ID No.: _____ Group No.: _____

Insurance company: _____ Insurance phone: _____

Insured's employer: _____ Work phone: _____

Employer address: _____ City, State, Zip: _____

Please indicate any secondary insurance you have: _____ Please tell me more about this ☐ Yes ☐ No

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child, and/or the individual that has appointed me as their legal representative or guardian (hereafter "I"), ever have a change in health, insurance, and or benefits. By signing this form, I certify I have insurance coverage with the above-named insurance company(ies), authorize the use of my signature on all insurance submissions, and assign directly to Daron Halle Chiropractic all insurance benefits payable for services rendered. I also hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical condition(s), accident(s), injury(ies), illness(es), past or future condition, to pay directly to and exclusively in the name of Ellah Health Specialties, Inc., dba Daron Halle Chiropractic, such sums as may be owing for charges incurred by me for any and all service(s) rendered. Whether or not reimbursed by any or all of these entities, I understand that I am financially responsible for all charges.

Dr. Halle may use my healthcare information and may disclose such information to the above-referenced payers and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

_____ _____

Signature of patient, parent, or legal representative/guardian Date

_____ _____

Printed name of patient, parent, or legal representative/guardian Relationship to patient

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NOTICE OF PRIVACY PRACTICES

Patient name (please print):_____

All health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Call, text. and/or email to remind you of scheduled or missed appointments
- Thank you for referring patients
- Inquire about your eligibility, benefits, and/or claims
- Include you in care classes
- Discuss your care with family. Please indicate those family members with whom your information can be shared:

  _____

  _____

  _____

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation
- Discussing your claim(s)

You have the right to:

- Request a copy of your health record
- Request with whom we share your health information
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your health information

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy.
- I understand any questions can be directed to clinic management.
- The doctor(s), employees, or designated agents of this clinic may use my protected health information in the manner previously described.

Signature of patient, parent, or legal representative/guardian	Date
Printed name of patient, parent, or legal representative/guardian	Relationship to patient

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INFORMED CONSENT

Patient name (please print):_____

I hereby request and provide consent for Dr. Daron Halle (Dr. Halle) to perform chiropractic manipulation and/or diagnostic X-rays on me or on the patient named below, for whom I am the parent or am legally responsible. I also hereby request and provide consent for Dr. Halle, or his designated and supervised staff member, to perform physical medicine modalities and therapeutic procedures.

I understand that chiropractic manipulation is a specific adjustment for subluxation, that is, a joint that has lost its ability to move and function properly. Abnormal movement patterns and improper function will continue and may negatively impact nerve activity unless corrected. In order to correct this, I understand that Dr. Halle will use his hands or the necessary instruments to move joints within the affected area. The movement of joints can create an audible "pop" or "click." This is caused by gasses within the joint being released when it is adjusted.

I understand and am informed that, as in the practice of medicine, there are risks of treatment in the practice of chiropractic. These risks are rare but can include and are not limited to fractures, disk injuries, dislocations, sprains, strains, stroke, and other symptoms.

Other chiropractic procedures involve physical medicine modalities (e.g., electrical muscle stimulation, traction, decompression, ultrasound, infrasound, application of cold and/or hot packs, exercises, stretching protocols, gait modification, balancing, etc.) and therapeutic procedures (e.g., trigger point therapy, massage therapy, etc.). I understand these procedures may result in muscle strain, muscle spasms, ligament sprain, local bruising, burns, dizziness, temporary aggravation, and other symptoms.

I do not expect Dr. Halle to be able to anticipate and explain all risks and complications. I wish to rely upon Dr. Halle to exercise judgment during the course of the procedure(s) which he feels at the time is/are in my best interest. I understand that Dr. Halle's judgment is based upon the facts known to him professionally as well as those that I have disclosed to him. I understand the importance of disclosing all medical information to Dr. Halle so I can be treated appropriately and have truthfully and fully shared all medical information with him. I will notify Dr. Halle immediately to explain any negative symptoms so a necessary evaluation may be performed and corrective actions may be implemented.

I have had an opportunity to discuss the nature and purpose of chiropractic manipulation and other procedures with Dr. Halle. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and have had my questions answered satisfactorily. 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. By signing below, I state that I have weighed the risks involved with treatment and have decided it is in my best interest to undergo recommended treatment. Having been informed of possible risks, I hereby give my consent to undergo recommended treatment. I understand that it is my responsibility to inform my doctor if I ever have a change in health or experience negative symptoms.

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POLICIES AND PROCEDURES FOR OUR PATIENTS

Patient name (please print):_____

Welcome to our office! *We hope these policies and procedures help prevent any misunderstandings. Please let us know if you have any questions.*

↑ *Initials*	**Clinic hours** Our office is open Monday through Friday for your convenience. Appointments are available at many times of the day including early mornings, during lunch, and early evenings. To better serve you, and to ensure you stay on track with your treatment plan, please schedule your future appointment(s) before leaving the office. Appointments outside of clinic hours will be charged an after hours fee (weekdays $50, weekends $75, and holidays $100) in addition to services rendered.
↑ *Initials*	**Appointments** If you need to change an appointment, a 24-hour advance notice must be provided to the office. If a 24-hour advance notice isn't provided, you will be charged for the missed appointment (30-minute massage $45, 60-minute massage $65, 90-minute massage $85, and/or chiropractic $45). All missed appointments should be made up within the same week so that you stay on track with your treatment plan. Deviating from your treatment plan will interfere with healing and progress, so please keep your appointments. If you haven't notified us to reschedule a missed appointment, we will contact you because keeping you on track matters to us. We will regretfully dismiss you from care if appointments are repeatedly missed. Missing your appointments will interfere with the corrective process of your care but and with Dr. Halle's ability to provide care to other patients.
↑ *Initials*	**Visit procedure** Each time you arrive for your visit, you are required to sign-in electronically. Any of our staff members are available to assist you if necessary. The electronic sign-in allows you to select where, how, and what you are feeling and allows Dr. Halle to focus on the problem area(s). Please note that when indicating your pain level on a scale from 1 to 10, it is important that you indicate the worst pain level you've experienced since the time you first started noticing symptoms. This sign-in process is critical because it allows Dr. Halle to evaluate your progress or notice if problems keep recurring. After completing the sign-in process, please have a seat in the reception area until you are directed to the treatment waiting area or a treatment room. Dr. Halle will review your reported information and examine your problem area(s). Chiropractic treatment will take only a few minutes and may be followed by other necessary therapies as determined by Dr. Halle.
↑ *Initials*	**Symptoms** Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected, having good days and bad days is normal. A certain number of adjustments in a given time period is necessary to get the best results from your care. While we can't predict the exact number of adjustments you will need, we do know that consistency with your treatment plan creates the best results. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. *This takes time* and can be a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey. Please notify Dr. Halle immediately of any negative symptom(s) you experience.
↑ *Initials*	**Communication** Please know that it is Dr. Halle's personal and professional goal to get you to *experience optimal health*. If this is also your goal, it is pivotal that you communicate about any change in your health, your progress, provide feedback about treatments and therapies that you are and/or aren't responding to, and inform Dr. Halle about external circumstances or situations that could be hindering your progress. Additionally, Dr. Halle wants to hear from you about how his office is performing or any other concerns that you might have.
↑ *Initials*	**Nutritional and health aids** Our office offers a wide array of nutritional aids such as vitamins, supplements, medical food, and essential oils. Health aids such as mattresses, custom orthotics, pillows, ice packs, TENS units, etc. are also offered. Dr. Halle has contracted with top chiropractic suppliers and vendors to make the best yet most reasonably priced products available to you. While we may not have something on-hand, we can special order any item that is necessary for your care. Please consult with Dr. Halle prior to any requests or purchases to ensure you are getting the proper aids so there is no interference with your healing and progress. Please note these products are subject to applicable sales taxes and are non-refundable.

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POLICIES AND PROCEDURES FOR OUR PATIENTS (*continued*)

↑ *Initials*	**Financial responsibility and arrangements**
	We are committed to providing you the best chiropractic care possible and hope to help you achieve the level of health that you desire. In order to do that, we need your assistance by understanding the following:
	• Advance notification of at least 2 business days is required to verify any insurance changes. No new insurance will be accepted the same day as your appointment. You will be responsible for paying the prevailing self-pay rates for any services rendered until our staff has had sufficient time to verify your benefits and estimate future charges.
	• Payment for services provided is expected at the time they are rendered unless other arrangements are authorized by our office. We accept all major credit cards, personal checks, money orders, cashier's checks, and cash.
	• If you have health insurance, a personal injury claim, or workers compensation claim, we will submit your claim(s) to the appropriate party as a courtesy for you. We will gladly attempt to answer your questions relating to this claim; however, you must realize that:
	  ○ You are responsible to inform our office about a change in insurance, benefits, at-fault party information, etc.
	  ○ Not all services are a covered benefit or will be paid by a claim. In some instances, we have found that insurance companies will deny or reduce benefits or claims despite our best efforts to demonstrate the necessity for the care provided.
	  ○ Your health insurance coverage is based on a contract between you and that company—we are <u>not</u> a party to that contract. Therefore, all charges, whether or not paid by insurance, at-fault party, etc., are ultimately your financial responsibility.
	  ○ If in the event full payment for services provided isn't made through settlement of a claim, you are responsible for making a full payment on any outstanding balance on your account. We must emphasize that as a health care provider, our relationship is with you, <u>not</u> with the claim payer.
	• Personal checks returned for insufficient funds will be subject to the charges imposed on our office by the financial institution.
	• Any outstanding balance over 30 days is charged a minimum fee of $2.50 per month or interest at 1.5% per month, whichever is greater.
	• Any outstanding balance over 90 days is subject to collection by an outside agency. You will be responsible for paying your outstanding balance, the accrued monthly fees, all collection fees, and any other fees incurred as a result of the collection effort.
	• Payment arrangements are available, but they need to be established at the time of or before care is initiated.
	• If your insurance doesn't offer chiropractic benefits, please speak with our office. Every attempt will be made to provide affordable chiropractic care.

I have read, or have had read to me, the above policies and procedures. I have also had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that these policies and procedures are not intended to be all-inclusive and other matters may arise that aren't discussed here. By signing below, I state that I agree to comply with stated or implied policies and procedures.

Signature of patient, parent, or legal representative/guardian	Date
Printed name of patient, parent, or legal representative/guardian	Relationship to patient

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PATIENT HEALTH HISTORY

Patient name (please print):_____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD AND HOW OFTEN IT OCCURS/OCCURRED:

OCCASIONAL	FREQUENT	CONSTANT	MUSCLE & JOINT
			Arthritis
			Bursitis
			Carpal tunnel
			Foot trouble
			Hernia
			Low back pain
			Neck pain or stiffness
			Pain between shoulders
			Pain or numbness in:
			Shoulders
			Arms
			Elbows
			Hands
			Hips
			Legs
			Knees
			Feet
			Tail bone
			Poor posture
			Sciatica
			Spinal curvature (scoliosis)
			Swollen joints

OCCASIONAL	FREQUENT	CONSTANT	GENERAL
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fatigue
			Fever
			Headache
			Loss of sleep
			Nervousness/depression
			Neuralgia (nerve pain)
			Numbness
			Sweats
			Tremors
			Weight loss

OCCASIONAL	FREQUENT	CONSTANT	WOMEN
			Cramps or backache
			Excessive menstrual flow
			Hot flashes
			Irregular cycle
			Menopausal symptoms
			Painful menstruation
			Vaginal discharge
			Pregnant? ☐ Yes ☐ No
			Weeks:

OCCASIONAL	FREQUENT	CONSTANT	EYES, EARS, NOSE, & THROAT
			Asthma
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Earache
			Ear discharge
			Ear noises
			Enlarged glands
			Enlarged thyroid
			Eye pain
			Failing vision
			Farsighted
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Nearsighted
			Nose bleeds
			Sinus infection
			Sore throat
			Tonsillitis

OCCASIONAL	FREQUENT	CONSTANT	GASTROINTESTINAL
			Belching or gas
			Colitis
			Colon trouble
			Constipation
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Excessive hunger
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Liver trouble
			Nausea
			Pain over stomach
			Poor appetite
			Vomiting
			Vomiting of blood

OCCASIONAL	FREQUENT	CONSTANT	CARDIOVASCULAR
			Hardening of arteries
			High blood pressure
			Low blood pressure
			Pain over heart
			Poor circulation
			Rapid heartbeat
			Slow heartbeat
			Swelling of ankles

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PATIENT HEALTH HISTORY (*continued*)

OCCASIONAL	FREQUENT	CONSTANT	GENITOURINARY
			Bedwetting
			Incontinence
			Blood or pus in urine
			Frequent urination
			Kidney infection or stones
			Painful urination
			Prostate trouble

OCCASIONAL	FREQUENT	CONSTANT	RESPIRATORY
			Chest pain
			Chronic cough
			Difficult breathing
			Spitting up blood
			Spitting up phlegm
			Wheezing

OCCASIONAL	FREQUENT	CONSTANT	SKIN
			Boils
			Bruise easily
			Dryness
			Hives or allergy
			Itching
			Skin eruptions (rash)
			Varicose veins

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever had previous chiropractic care? ☐ Yes ☐ No *If yes, date of last care and doctor name or location:*_____

What is your major complaint? _____

Other complaints?_____

How long have you had these complaints?_____ Have you had these or similar complaints in the past? ☐ Yes ☐ No

What activities aggravate your complaints? ☐ Coughing ☐ Sneezing ☐ Reaching ☐ Bending ☐ Lifting ☐ Sitting ☐ Standing ☐ Walking

☐ Other, please describe:_____

Are these complaints getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Are these complaints interfering with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Other, please describe_____

Are your complaints the result of an ☐ On the job accident ☐ Auto accident ☐ Other, please describe_____

Was the accident within: ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Briefly describe your accident:_____

Please list previous diagnoses and treatments you've received for these complaints:_____

_____

How long has it been since you've felt good?_____ What do you believe is wrong?_____

Age of mattress:_____ ☐ Comfortable ☐ Uncomfortable Age of pillow:_____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Arch supports (orthotics)

HAVE YOU EVER:

Been treated for a spine or nerve disorder? ☐ Yes ☐ No Describe:_____

Had a fractured bone? ☐ Yes ☐ No Describe:_____

Been hospitalized for other than surgery? ☐ Yes ☐ No Describe:_____

PLEASE CHECK OR LIST ALL CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST 10 YEARS:

☐ Alcoholism	☐ Chorea	☐ Epilepsy	☐ Malaria	☐ Pleurisy	☐ Thyroid
☐ Anemia	☐ Cold sores	☐ Fever blisters	☐ Measles	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Diabetes	☐ Gout	☐ Miscarriage(s)	☐ Polio	☐ Typhoid fever
☐ Arteriosclerosis	☐ Diphtheria	☐ Heart disease	☐ Multiple sclerosis	☐ Rheumatic fever	☐ Ulcers
☐ Arthritis	☐ Eczema	☐ HIV/AIDS	☐ Mumps	☐ Scarlet fever	☐ Venereal disease
☐ Cancer	☐ Emphysema	☐ Influenza	☐ Parkinson's	☐ Stroke	☐ Whooping cough

☐ Other, please list: _____

_____

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PATIENT HEALTH HISTORY (*continued*)

Please list surgical operations and years: _____

_____

DO YOU:

Take medications? ☐ Yes ☐ No *If yes, please list OR provide separate list:*_____

_____

_____

_____

Take vitamins, minerals, supplements? ☐ Yes ☐ No *If yes, please list:*_____

_____

Have an allergy to any drug? ☐ Yes ☐ No *If yes, please describe:*_____

_____

APPROXIMATE DATE OF LAST:	**Less than 6 months**	**6–18 months**	**Over 18 months**	**Never**
Spinal examination	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

FAMILY HEALTH INFORMATION

Diagnosis	Father	Mother	Sibling	Offspring
(Example: heart disease)	*(X)*			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child, and/or the individual that has appointed me as their legal representative or guardian, ever have a change in health.

_____ _____

Signature of patient, parent, or legal representative/guardian | Date

_____ _____

Printed name of patient, parent, or legal representative/guardian | Relationship to patient

CLINIC USE ONLY

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____

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ACCIDENT HISTORY

Patient legal name (please print):_____

SYMPTOMS, INJURIES, AND TREATMENT

Please indicate any part of your body hit during the accident (e.g., head on dash, chest on steering wheel, etc.):_____

Please indicate any bones broken as a result of the accident:_____

Were you completely conscious after the impact? ☐ Yes ☐ No Do you remember the impact? ☐ Yes ☐ No

Describe any unusual events you experienced during or immediately after the accident:_____

Where were you taken after the accident?_____ Were you hospitalized? ☐ Yes, how long_____ ☐ No

Where did you feel pain?_____

Did you receive treatment/care at another facility? ☐ Yes, specify:_____ ☐ No

Have you ever been injured in a similar manner? ☐ Yes, how and when?_____ ☐ No

Did you receive any outside help (home health aide, etc.): ☐ Yes ☐ No

Did you lose any time from work, school, or other activities due to accident: ☐ Yes ☐ No

Does it bother you to operate a vehicle now? ☐ Yes ☐ No Or to be a passenger? ☐ Yes ☐ No

ACCIDENT INFORMATION

Were you the operator? ☐ Yes ☐ No Were you a passenger? ☐ Yes ☐ No Was it your vehicle? ☐ Yes ☐ No

Your vehicle "1" year/make/model:_____

Other vehicle "2" year/make/model:_____

Other vehicle "3" year/make/model:_____

Did the accident happen at/in a:

Stop sign ☐ Yes ☐ No Traffic light ☐ Yes ☐ No Intersection ☐ Yes ☐ No Parking lot ☐ Yes ☐ No

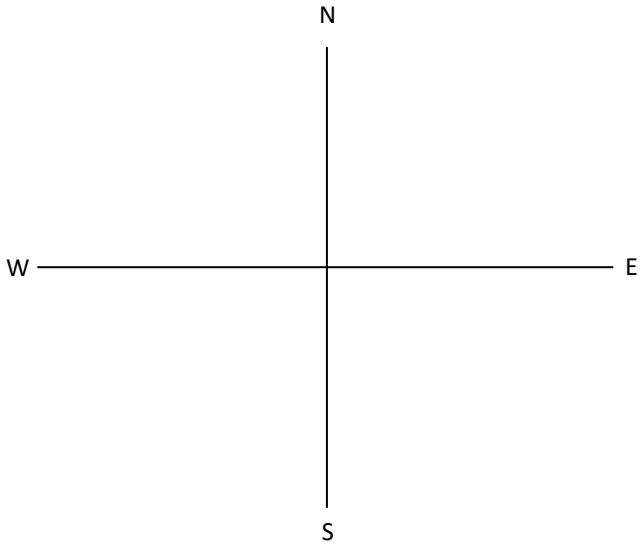
Describe how and where the accident happened in your own words:_____

_____

_____

_____

Please draw the accident below. Reference your vehicle as [1] and other vehicles involved in the accident as [2], [3], etc.



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ACCIDENT HISTORY (*continued*)

PATIENT INSURANCE INFORMATION

Patient's driver license # / state:_____
Date of accident:_____
Patient's auto insurance carrier:_____
Policy #: _____ Exp. date:_____
Address:_____
Med Pay: ☐ Yes, indicate limit:_____ ☐ No
Adjustor name:_____ Phone #:_____
Claim #:_____
Are you using an attorney: ☐ Yes ☐ No
If yes, name, address, & phone #:_____
Police report: ☐ Yes ☐ No
Exchange of auto insurance form: ☐ Yes ☐ No

AT FAULT DRIVER / INSURANCE INFORMATION

Name:_____
Address:_____
Auto insurance carrier:_____
Policy #: _____ Exp. date:_____
Address:_____
Adjustor name:_____ Phone #:_____
Claim #:_____

_____ _____
Signature of patient, parent, or legal representative/guardian Date

_____ _____
Printed name of patient, parent, or legal representative/guardian Relationship to patient

CHECKLIST OF WHAT TO BRING TO YOUR APPOINTMENT

☐ completed paperwork
☐ driver's license or photo ID
☐ medical insurance card
☐ declarations page from your automobile insurance policy
☐ accident exchange information
☐ police report
☐ any photographs of the involved vehicles at the accident scene
☐ attorney's contact information
☐ any medical records as it relates to your injury
☐ list of prescription and over-the-counter medications
☐ names and phone numbers of other physicians you are seeing for your injury

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NOTICE OF INTENT TO FILE LIEN AND PATIENT FINANCIAL RESPONSIBILITIES

Patient name (please print):_____

As a patient in our office that is involved in a personal injury case, we will submit the claim(s) to the appropriate party for services rendered (your healthcare costs incurred at this office) as a courtesy to you. However, it is our policy to file a lien to ensure that payment is obtained for those services.

A lien is an official claim against your settlement for payment of an amount owed to our office for services rendered. It is filed with the Maricopa County Recorder's office, has become standard practice in the healthcare industry, and is allowed by Arizona state law (A.R.S. 33 § 931 et al, <http://www.azleg.gov/ArizonaRevisedStatutes.asp?Title=33>).

A copy of the recorded lien will be delivered to you by Certified Mail, for your records. When our office receives payment in full, the lien will be released and a copy of the release will be sent to you by First Class Mail.

Please be assured that this is not a lien against your property. It is also not against you as the patient and is not a reflection of your integrity. The lien itself will not be picked up by credit reporting agencies.

There are various possible scenarios of and outcomes to personal injury cases. The below examples are most common but are not intended to be all-inclusive; however, they are prioritized in the order that our office will handle the billing for services rendered:

If you are determined to be the at-fault party, you agree to the following:

- Our office may directly bill the medical payments portion of your automobile insurance policy, and/or
- Our office may submit a claim to your health insurance

If another party is determined to be the at-fault party, you agree to the following:

- Our office may directly bill the medical payments portion of your automobile insurance policy, and/or
- Our office may bill the at-fault party, and/or
- Our office may submit a claim to your health insurance

Use of the medical payments coverage from your automobile insurance policy

Whether you or another party was determined to be at-fault, we may bill the medical payments portion of your automobile insurance policy. Your insurance company may mail the payment(s) directly to you for services rendered. In this case, you must immediately forward the payment(s) to our office.

At the time of your case settlement

A settlement check may be payable jointly to *you and your doctor(s)*. The total amount of that check would include the total amount for services rendered at this office. Due to the presence of a recorded lien by our office, you are obligated to pay us directly for all services rendered. You must immediately deliver that check to our office to pay your outstanding account balance. If for some reason your settlement doesn't cover the cost of the services rendered, you are directly and fully responsible to pay the outstanding balance.

A settlement check may be payable jointly to *you and your attorney*. The total amount of that check would include the total amount for services rendered at this office. Due to the presence of a recorded lien by our office, your attorney is obligated to pay us directly for all services rendered. Your attorney may mail us a check directly; however, it remains your responsibility to verify that all financial matters with this office are fully resolved. If for some reason your settlement doesn't cover the cost of the services rendered, you are directly and fully responsible to pay the outstanding balance.

Standard patient policies and procedures

- You are responsible to inform our office about a change in insurance, benefits, at-fault party information, etc.
- Not all services are a covered benefit or will be paid by a claim(s). In some instances we have found that insurance companies will deny or reduce benefits or claims despite our best efforts to demonstrate the necessity for the care provided.
- Your health or automobile insurance coverage is based on a contract between you and that company—we are <u>not</u> a party to that contract. Therefore, all charges, whether or not paid by insurance, at-fault party, etc., are ultimately your financial responsibility.

DARON HALLE CHIROPRACTIC

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NOTICE OF INTENT TO FILE LIEN AND PATIENT FINANCIAL RESPONSIBILITIES (*continued*)

Standard patient policies and procedures (*continued from previous page*)

- If in the event full payment for services provided isn't made through settlement of a claim, you are responsible for making a full payment on any outstanding balance on your account. We must emphasize that as a health care provider, our relationship is with you, not with the claim payer.
- When accepting a settlement from the at-fault party, it absolves that at-fault party from considering or actually paying further claim(s) related to this particular accident. So, if some reason your settlement doesn't cover the cost of the services rendered, you are directly and fully responsible to pay the outstanding balance.
- Personal checks returned for insufficient funds will be subject to the charges imposed on our office by the financial institution.
- Any outstanding balance over 60 days is charged interest at one-and-one-half percent (1.5%) per month.
- As stated earlier, the lien itself will not be picked up by credit reporting agencies; however, your failure to pay the total amount for services rendered within 90 days of settlement will force us to notify credit bureaus and commence collection efforts. You will be responsible for paying your outstanding balance, the accrued monthly interest, all collection fees, and any other fees incurred as a result of the collection effort.
- Payment arrangements are available but they need to be established at the time of or before care is initiated.

Taking care of your health is our number one priority, but we also want to prevent any misunderstandings. Please feel free to ask our office any questions that you may have related to your personal injury case or if clarification of these terms and conditions is needed.

I have read, or have had read to me, the above terms and conditions. I have also had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that a healthcare lien will be filed. I also understand these terms and conditions are not intended to be all-inclusive and other matters may arise that aren't discussed here. By signing below, I agree to comply with stated or implied terms and conditions and I fully understand that I am directly and fully responsible for payment of all services rendered.

Signature of patient, parent, or legal representative/guardian	Date
Printed name of patient, parent, or legal representative/guardian	Relationship to patient