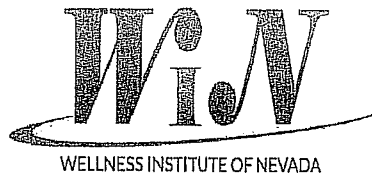
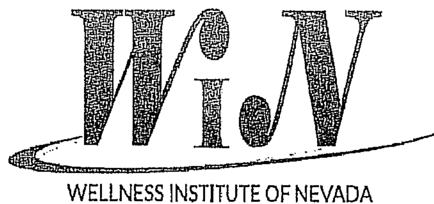


Welcome to the Office of Wellness Institute of Nevada

Listed below are helpful hints to better understand our office and how to complete the patient packets

1. Please remember to bring I.D and insurance card.
2. If you have medical records from another doctor's office, Quick Care, or hospital, please give them to our staff upon arrival. Our doctor will review them for proper diagnosis.
3. It is your responsibility to know your insurance. Due to the exactitude of insurances, you will not be seen until *all insurances* have been verified and referrals, if applicable, have been received.
4. It is our desire to have your health insurance or government program pay your claims in a timely manner. Your insurance requires detailed and completed information. Often your information must be mailed in as part of the medical record.
5. Health insurance claims are processed due to health issues *not* associated with workers' compensation claims, auto accidents, legal claims or any other third party liability.
6. If you had an accident and it is a third party liability, we will provide you and/or your attorney with the paperwork that is required.
   a. If you have or will retain an attorney, payment will be required at the time of service unless or until a Lien (on our form) has been signed by you and your attorney. We always reserve the right to refuse to accept a Lien in lieu of payment at the time of service. Additionally, a Lien is *not* a contingency agreement. Payment to us must be made within a reasonable time whether or not the third party is found to be at fault and whether or not payment from the third party is sufficient to cover all costs incurred for our services.
   b. If you do not retain an attorney, you will have to bill everything on your own, monitor your own case with the third party liability company, and make monthly payments until your case is resolved. You are considered a "private pay."
7. Please do not leave anything blank in the patient packet.
8. Please ask us for help if something needs to be clarified. We are here to help you.

Better Health. Better Life.



Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.

2. You may be entitled to a network or contractual discount under the following circumstances:

    a. We are a participating provider in your health plan.

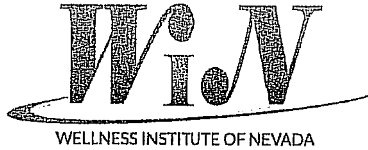
    b. You are covered by a State or Federal program with a mandated fee schedule.

    c. You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our staff for more information.

3. As part of our compliance plan, as of August 1, 2014, our office will be unable to extend any type of discounts other than those listed above.

Acknowledged By: ____

Date: ____________________________



NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient's First Name__________ Middle________ Last__________ Date ________

Address __________ City ________ Zip Code ______ Home Phone ________

Cell Phone________ E-mail __________ Social Security # ________

Employer Name __________ Job Title __________ Work Phone # ________

Date of Birth ______ Age____ Gender __Male __Female Handedness? ___R ___L Weight______ Height ______

Marital Status __Single __Married __Widowed __ Minor __Divorced __Domestic Partnership

Spouse's / Partner's Name__________ Spouse's / Partner's Date of Birth ________

Spouse's / Partner's Employer Name __________

How did you hear about us__________ If referral, who may we thank for the referral ________

Person responsible for this account__________ Relationship to Patient________

In case of emergency, whom should we contact?__________ Phone #________

Family physician________ Phone #________ Address________ City______ Zip_ ______

HEALTH INSURANCE INFORMATION

Primary Insurance

Health Insurance Company ________ Phone #________ Policy/Member ID #________ Group #________

Address __________ City ________ Zip Code ______ Phone Number ________

Name of the insurance card holder__________ Social Security # of card holder ________

Name of their employer__________ Employer Phone Number________

Secondary Insurance (If Applicable)

Health Insurance Company ________ Phone #________ Policy/Member ID #________ Group #________

Address __________ City ________ Zip Code ______ Phone Number ________

Name of the insurance card holder__________ Social Security # of card holder ________

Name of their employer__________ Employer Phone Number________

VEHICLE INSURANCE INFORMATION (***only complete this section if your visit is related to an automobile accident***)

Car Insurance Company __________ Address __________ City ______ Zip Code ______

Adjuster __________ Phone #________ Agent __________ Phone # ________

Policy # __________ Claim # __________ Drivers License # __________

Name of Insured on your Car Policy __________ Date of Loss/Accident? ______ Medical Coverage? ______

Uninsured Motorist Coverage? ______ Underinsured Motorist Coverage?______ Personal Injury Protection (PIP) Y N $______

Medical expenses to date resulting from accident? $__________ Lost wages since accident $__________

Better Health. Better Life.

What is the repair amount of your car? $ ________________ Lawyer/Law Firm (if applicable)____

Phone #______________________ Address ____ City _________________ Zip Code ____________

OTHER INFORMATION

Is this Workman's Compensation?_______ Is this Personal Injury?_________ Other cause of your accident/injury?_________ Explain_________

____

____

Have you received any medical treatment since your accident/injury? Y N If yes, date you first saw any Doctor after accident/injury_________

Hospital_____________________________________ Cost________ Medical Doctor _____________________________________ Cost__________

Chiropractor___________________________________ Cost________ Other____ Cost__________

SYMPTOMS

Patient's Name______________________________ Date of incident ________________Today's Date________________

CIRCLE ALL YOUR COMPLAINTS

1. **DO YOU HAVE LACERATIONS, CUTS OR BRUISING?:**
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
2. **HEAD INJURIES:** (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Difficulty remembering things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in sexual functioning
   dd. Nausea / Vomiting
   ee. Change in personality
   ff. Wanting to be alone
   gg. Mood swings
   hh. Sadness
   ii. Agitation
   jj. Anger
   kk. Helplessness
   ll. Reduced confidence
   mm. Apathy
   nn. Irritability
   oo. Sleepiness
   pp. Frustration
   qq. Impatience
   rr. Other head related Issues
   ____
3. **NECK INJURIES:**
   a. Neck pain
   b. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   e. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   f. Neck pain that causes headaches
   g. Neck spasms or shoulder spasms
   h. Popping, clicking or clunking sound with neck movement
4. **MID BACK PAIN OR UPPER BACK PAIN:**
   a. Upper or mid back pain
   b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Upper or mid back spasms
5. **LOW BACK PAIN:**
   a. Low back pain
   b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
   c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
   d. Low back spasms
6. **PELVIC OR SACRAL PAIN:**
   a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
   b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
   c. Sacral pain (tail bone)
   d. Coccygeal or coccyx (tail bone) pain
7. **JAW PROBLEMS:**
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side
8. **SHOULDER INJURIES**
   a. Shoulder pain LEFT RIGHT BOTH
   b. Shoulder pain with movement L R BOTH
   c. Shoulder spasms LEFT RIGHT BOTH
   e. Sharp shoulder pain
   f. Dull shoulder pain
   g. Achy shoulder pain
   h. Pins and needles shoulder pain
   i. Shoulder pain that radiates or shoots pain into arm
   j. Other: ______________________________

9. **UPPER ARM PAIN**: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other ______________________________
10. **ELBOW PAIN**: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other ______________________________
11. **FOREARM**: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other______________________________
12. **WRIST PAIN**: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other ______________________________
13. **HAND PAIN**: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other ______________________________
14. **HIP PAIN**: RIGHT LEFT BOTH
   a. Hip pain
   b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot
15. **UPPER LEG PAIN**: RIGHT LEFT BOTH
   a. Upper leg pain that radiates to knee
   b. Upper leg spasms
16. **KNEE PAIN**: RIGHT LEFT BOTH
   a. Knee pain that radiates to calf
   b. Knee pain that radiates to calf and ankle
   c. Knee pain that radiates to calf, ankle and foot
17. **ANKLE PAIN**: RIGHT LEFT BOTH
   a. Ankle pain that radiates to foot
   b. Ankle and foot pain
18. **FOOT PAIN:** RIGHT LEFT BOTH
19. **CHEST PAIN**
20. **STOMACH PAIN**
21. **OTHER SYMPTOMS**: ______________________________

____

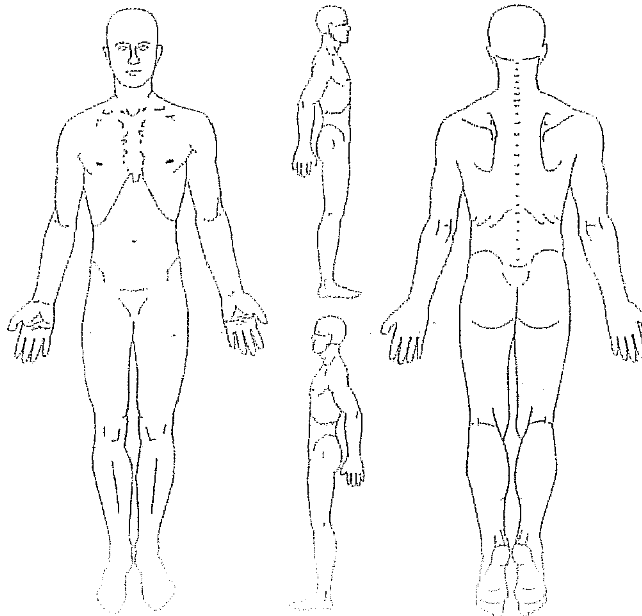
____

____

____

Patient's Name________________________________ Today's Date__________________

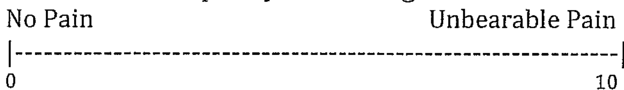
Please draw the location of your pain or discomfort on the image below. Use the symbols shown to represent the type(s) of pain.



Below, please draw a vertical line representing your pain or discomfort on a scale of 0-10:

Rate the pain you have right **now:**

No Pain Unbearable Pain

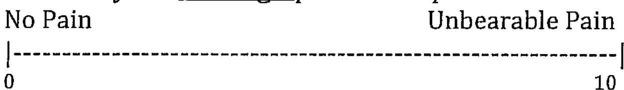


Rate your pain at its **best** in the past week:

No Pain Unbearable Pain

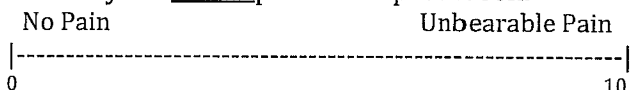
Rate your **average** pain in the past week:

No Pain Unbearable Pain



Rate your **worst** pain in the past week:

No Pain Unbearable Pain



EXACERBATING FACTORS

Check all below that make your **NECK** hurt more	Check all below that make your **UPPER BACK** hurt more	Check all below that make your **LOW BACK** and/or **PELVIS AREA** hurt more
_____Laying on pillow	_____Laying in bed	_____Laying in bed
_____Turning neck	_____Sitting	_____Sitting
_____Looking up	_____Bending	_____Bending
_____Looking down	_____Twisting	_____Twisting
_____Combing hair	_____Lifting	_____Lifting
_____Computer at work	_____Dressing	_____Pushing/Pulling
_____Computer at home	_____Computer at work	_____Computer at work
_____Working	_____Computer at home	_____Computer at home
_____Sports	_____Working	_____Working
_____Driving	_____Sports	_____Sports
_____Other (please list other things that make your neck hurt)	_____Driving	_____Driving
	_____Other (please list other things that make your upper back hurt)	_____Other (please list other things that make your neck hurt)

Patient's Name________________________________ Today's Date________________

NECK INDEX

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem,

Pain Intensity
0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

Sleeping
0 I have no trouble sleeping
1 My sleep is slightly disturbed (less than 1 hour sleepless)
2 My leap is mildly disturbed (1-2 hours sleepless)
3 My sleep is moderately disturbed (2-3 hours sleepless)
4 My sleep is greatly disturbed (3-5 hours sleepless)
5 My sleep is completely disturbed (5-7 hours sleepless

Reading
0 I can read as much as I want with no neck pain
1 I can read as much as I want with slight neck pain
2 I can read as much as I want with moderate neck pain
3 I cannot read as much as I want because of moderate neck pain
4 I can hardly read at all because of sever neck pain
5 I cannot read at all because of neck pain

Concentration
0 I can concentrate fully when I want with no difficulty
1 I can concentrate fully when I want with some difficulty
2 I have a fair degree of difficulty concentrating when I want
3 I have a lot of difficulty concentrating when I want
4 I have a great deal of difficulty concentrating when I want
5 I cannot concentrate at all

Work
0 I can do as much work as I want
1 I can only do my usual work but no more
2 I can only do most of my usual work but no more
3 I cannot do my usual work
4 I can hardly do any work at all
5 I cannot do any work at all

Personal Care
0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself and I am slow and careful
3 I need some help but I manage most of my personal care
4 I need help every day in most aspects of self care
5 I do not get dressed, I wash with difficulty and stay in bed

Lifting
0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights of the floor, but I can manage if they are conveniently positioned (e.g., on a table)
3 Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned
4 I can only lift very light weights
5 I cannot lift or carry anything at all

Driving
0 I can drive my car without any neck pain
1 I can drive my car as long as I want with slight neck pain
2 I can drive my car as long as I want with moderate neck pain
3 I cannot drive my car as long as I want because of moderate neck pain
4 I can hardly drive at all because of severe neck pain
5 I cannot drive my car at all because of neck pain

Recreation
0 I am able to engage in all my recreation activities without neck pain
1 I am able to engage in all my usual recreation activities with some neck pain.
2 I am able to engage in most but not all my usual recreation activities because of neck pain
3 I am only able to engage in a few of my usual recreation activities because of neck pain
4 I can hardly do any recreation activities because of neck pain
5 I cannot do any recreation activities at all

Headaches
0 I have no headaches at all
1 I have slight headaches which come infrequently
2 I have moderate headaches which come infrequently
3 I have moderate headaches which come frequently
4 I have server headaches which come frequently
5 I have headaches almost all the time

For Office Use Only
Neck Index Score [ ]

Patient's Name______________________________ Today's Date________________

BACK INDEX

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem,

Pain Intensity
0 The pain comes and goes and is very mild
1 The pain is mild and does not vary much
2 The pain comes and goes and is moderate
3 The pain is moderate and does not vary much
4 The pain comes and goes and is very severe
5 The pain is very severe and does not vary much

Sleeping
0 I get no pain in bed
1 I get pain in bed but it does not prevent me from sleeping well
2 Because of pain my normal sleep is reduced by less than 25%
3 Because of pain my normal sleep is reduced by less than 50%
4 Because of my pain my normal sleep is reduced by less than 75%
5 Pain prevents me from sleeping at all

Sitting
0 I can sit in any chair as long as I like
1 I can only sit in my favorite chair as long as I like
2 Pain prevents me from sitting more than 1 hour
3 Pain prevents me from sitting more than ½ hour
4 Pain prevents me from sitting more than 10 minutes
5 Pain prevents me from sleeping at all

Standing
0 I can stand as long as I want without pain
1 I have some pain while standing but it does not increase with time
2 I cannot stand for longer than 1 hour without increasing pain
3 I cannot stand for longer than ½ hour without increasing pain
4 I cannot stand for longer than 10 minutes without increasing pain
5 I avoid standing because it increases pain immediately

Walking
0 I have no pain while walking
1 I have some pain while walking but it doesn't increase with distance
2 I cannot walk more than 1 mile without increasing pain
3 I cannot walk more than ½ mile without increasing pain
4 I cannot walk more than ¼ mile without increasing pain
5 I cannot walk at all without increasing pain

For Office Use Only

Back Index Score	

Personal Care
0 I do not have to change my way of washing or dressing in order to avoid pain
1 I do not normally change my way of washing or dressing even though it causes some pain
2 Washing and dressing increases the pain but I manage not to change my way of doing it
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it
4 Because of the pain I am unable to do some washing and dressing without help
5 Because of the pain I am unable to do any washing and dressing without help

Lifting
0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights of the floor
3 Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (e.g., on a table)
4 Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently position
5 I can only lift very light weights

Traveling
0 I get no pain while traveling
1 I get some pain while traveling but none of my usual forms of travel make it worse
3 I get extra pain while traveling which causes me to seek alternative forms of travel
4 Pain restricts all forms of travel except that done while lying down
5 Pain restricts all forms of travel

Social Life
0 My social life is normal and gives me no extra pain
1 My social life is normal but increases the degree of pain
2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
3 Pain has restricted my social life and I do not go out very often
4 Pain has restricted my social life to my home
5 I have hardly any social life because of pain

Changing Degree of Pain
0 My pain is rapidly getting better.
1 My pain fluctuates but overall is definitely getting better
2 My pain seems to be getting better but improvement is slow
3 My pain is neither getting better or worse
4 My pain is gradually worsening
5 My pain is rapidly worsening

HEALTH HISTORY

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐None ☐Other__________

Name and address of other doctor(s) who have treated you for your condition__________

Date of Last: Physical Exam______ Spinal X-Ray______ Blood Test______
Spinal Exam______ Chest X-Ray______ Urine Test______
Dental X-Ray______ MRI, CT-Scan, Bone Scan______

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

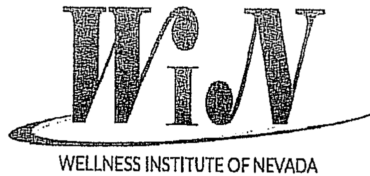
AIDS/HIV	☐Yes	☐No	Diabetes	☐Yes	☐No	Liver Disease	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Alcoholism	☐Yes	☐No	Emphysema	☐Yes	☐No	Measles	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Allergy Shots	☐Yes	☐No	Epilepsy	☐Yes	☐No	Migraine Headaches	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Anemia	☐Yes	☐No	Fractures	☐Yes	☐No	Miscarriage	☐Yes	☐No	STD	☐Yes	☐No
Anorexia	☐Yes	☐No	Glaucoma	☐Yes	☐No	Mononucleosis	☐Yes	☐No	Stroke	☐Yes	☐No
Appendicitis	☐Yes	☐No	Goiter	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No	Suicide Attempt	☐Yes	☐No
Arthritis	☐Yes	☐No	Gonorrhea	☐Yes	☐No	Mumps	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Asthma	☐Yes	☐No	Gout	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	Heart Disease	☐Yes	☐No	Pacemaker	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Breast Lump	☐Yes	☐No	Hepatitis	☐Yes	☐No	Parkinson's Disease	☐Yes	☐No	Tumors, Growths	☐Yes	☐No
Bronchitis	☐Yes	☐No	Hernia	☐Yes	☐No	Pinched Nerve	☐Yes	☐No	Typhoid Fever	☐Yes	☐No
Bulimia	☐Yes	☐No	Herniated Disk	☐Yes	☐No	Pneumonia	☐Yes	☐No	Ulcers	☐Yes	☐No
Cancer	☐Yes	☐No	Herpes	☐Yes	☐No	Polio	☐Yes	☐No	Vaginal Infections	☐Yes	☐No
Cataracts	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Prostate Problem	☐Yes	☐No	Whooping Cough	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Prosthesis	☐Yes	☐No	Other______	☐Yes	☐No
Chicken Pox	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Other______	☐Yes	☐No

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day______
☐ Moderate	☐ Standing	☐Alcohol	Drinks/Week______
☐ Daily	☐ Light Labor	☐Coffee/Caffeine Drinks	Cups/Day______
☐ Heavy	☐Heavy Labor	☐ High Stress Level	Reason______

Are you pregnant? ☐ Yes ☐ No Due Date______

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS



Wellness Institute of Nevada's Financial Policies and Assignment of Benefits

We, the staff at Wellness Institute of Nevada, thank you for choosing us as your provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If, at any time, you have any questions or concerns regarding our fees, policies or responsibilities, please feel free to contact us. We believe this level of communication and cooperation will allow us to continue to provide quality service to our valued patients.

All fees for medical care are based on the usual, reasonable , and customary fees charged in this area by physicians of equal training and experience.

Insurance:

Please remember that your insurance policy is a contract between you and your insurance carrier. We will bill your insurance, as a courtesy, to help you receive the maximum allowable benefit under your policy. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims. Final responsibility for payment of your account rests with you.

It is **your responsibility** to provide all necessary insurance eligibility, identification, and authorization and to *notify our office of any information changes when they occur*. We will verify chiropractic eligibility of your policy with your insurance company. However, **VERIFICATION OF COVERAGE DOES NOT NECESSARILY GUARANTEE PAYMENT FOR TREATMENT.** We are not expected to know all of your insurance policy's benefits and limitations. Additionally, you are responsible to know if W.I.N. is a participating or non-participating provider with your insurance plan.

Once a claim has been processed and approved, you may receive a bill for an outstanding balance for services. This can result from deductible, co-payment, or co-insurance policies between you and your insurance company. *Deductible is a flat amount a patient must pay before the insurer will make any benefit payments.* You will be personally responsible for your deductible and any co-insurance amount owed. Under state and federal law, and the provisions

of the insurance policy, **it is our responsibility to collect these patient responsibility amounts owed. We *cannot* legally discount fees for deductibles, co-payments or co-insurance after the submission on your behalf to your insurance carrier.**

Initials _________

Insurance Denials:

In the event of insurance denial and W.I.N. has properly submitted the claims, the patient is financially responsible for the ***FULL BILLED AMOUNT OF SERVICES*. This legally cannot be discounted to a lower fee.** If the patient believes that the insurance claim was denied in error by the insurance company, it is the **patient's responsibility** to contact the insurance company directly. We are willing to be lenient in waiting for resolution and payment if patient is diligent with communication to W.I.N.

Initials _________

Assignment of Benefits:

Having read the above, I hereby authorize payments by my insurance carrier, Medicare, Medicaid or other designated payers of medical benefits to Wellness Institute of Nevada for services to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize Wellness Institute of Nevada to release to my insurance carrier or their agents any medical information about me needed to determine these benefits payable for service.

I understand that if my account becomes delinquent and is assigned to an outside collection agency, that an additional mark up of 100% will be added to the amount I owe. I understand the adding of this collection fee as well as the accrual of interest at the statutory rate should my account be assigned to a collection agency. I agree to pay to Wellness Institute of Nevada for the services provided, collection fees if added and interest.

I hereby consent to and authorize medical treatment, tests, and procedures performed in this office that my physician deems advisable and necessary based on his/her judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

Initials _________

Insurance information

The specialty of chiropractic sometimes requires additional paperwork for your insurance company. Please be aware that you may receive special forms in the mail from your insurance company requesting:

-Accident Information
-Coordination of Insurance Benefits Information

Please respond immediately or bring the forms in to us and we will help you complete them free of charge.

If you do not respond to the insurance company within 30 days, they will delay your case and will not pay any claims. You will end up responsible for 100% of billed charges and will have no recourse to appeal.

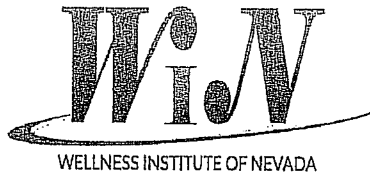
Initials _________

I have read and understand the above statements:

____
Printed Name of Patient

____
Signature of Patient or Authorized Representative

__ __/__ __/__ __ __ __
Date



CHIROPRACTIC CARE

Dear Patient:

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by the Federal Government (CMS) and the American Medical Association (the AMA). These regulations, which use an intricate system of codes for diagnosis and treatment purposes, can be quite complicated and generate many questions. If you ever have a question, please feel free to ask and we will try our best to explain.

Our office is required by the Federal Compliance laws to report the services provided based on the documentation in the medical records. As a matter of policy, we cannot improperly alter a claim for the purpose of obtaining payment. If you discover a bona fide billing error, duplicate charge or other posting error, we would greatly appreciate bringing the matter to the attention of our business office staff for further investigation and proper corrective action. Due to our contract with your insurance we cannot discount patient copays and deductibles.

As you well know, coverage and payment amounts vary greatly by payer. If you have any questions about your particular coverage, it is best to check with your company's representative. Our office staff will be happy to assist you in the claims filing process for prompt adjudication and payment of your insurance claim.

I have read and understand the above statements:

____

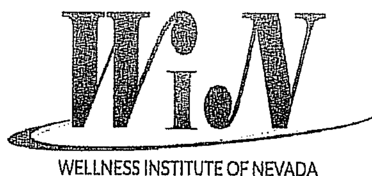
Printed Name of Patient

____

Signature of Patient or Authorized Representative

__ __/__ __/__ __ __ __

Date



Consent to Treat / Privacy Notice - HIPPA

I, ______________________, understand that, as in the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments there are various risks, the most common risks being temporary aggravation of my condition and/or soreness.

I do not expect the Chiropractic Physician(s) to be able to anticipate and explain all risks and complications, and I wish to rely on her to exercise judgment during the course of the procedure which she feels at the time, based on the facts then know, is in my best interest. I acknowledge that during the course of my care I may receive chiropractic adjustments, active release techniques, and physical therapy modalities, both passive and active.

I have read, or had read to me, the above consent and completely understand the treatment I will receive by the practitioners of Wellness Institute of Nevada (WIN) and hereby consent to receive treatment

______________________________ ______________

Signature of Patient or Representative Date

____

Print Name of Patient or Representative

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
• You can ask to see or get a copy of your medical record and other health information we have. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 20 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
• If you pay for a service or health care item out-of-pocket or other method in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

File a complaint if you feel your rights are violated
• You can complain if you feel we have violated your rights, by contacting us using the information on page 1.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
• We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory
If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treatment
We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about his/her overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more
information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use to share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

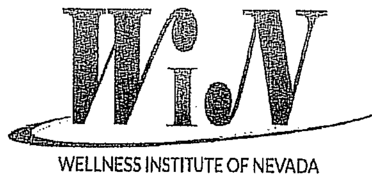
For more information see:
www/hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

I acknowledge receipt of this Notice of Privacy Practices.

_______________________________________ _____________________
Signature of Patient or Representative Date

____
Print Name of Patient or Representative



Appointment Policy

We are dedicated to providing you with the best care possible. To do so, Dr. Shana Singer will devise a treatment plan specifically for you and your situation. Treatment plans usually include the type, number, and frequency of visits projected to be required. For this reason, it is crucial that you do not miss appointments and adhere to the plan Dr. Singer gives you.

We, of course, understand that things come up and that it is not feasible to ask that you never cancel an appointment. Keep in mind, however, that if you do need to cancel an appointment, a make-up appointment should be scheduled.

Dr. Singer is responsible for your care. Therefore, it is our policy that if you miss 3 appointments within a one month period, we may discontinue your care due to the inability to adhere to the treatment plan. If you are unable to follow the treatment plan devised for you, please simply speak with Dr. Singer about your concerns and possible alternatives.

We take pride in keeping patient wait times to a minimum. You will likely notice that there is generally a short wait time when you come in. In order to keep wait times short, we ask that you schedule your appointment appropriately and in accordance with your treatment plan. Walk-ins are always welcome, but please remember we always take scheduled appointments first.

We ask that you please be considerate of the WIN employees and our other Patients and avoid no-shows. No-shows are particularly problematic when it comes to appointments with Massage Therapists, as the number of massages that can be performed per day is greatly limited. A massage therapy no-show not only deprives other Patients from the ability to receive a massage during that reserved time slot, it also deprives the Massage Therapist, who is paid on a per massage basis, from the ability to earn income during this no-show time period.

For these reasons, please understand that we reserve the right to impose a $25.00 fee for missed appointments without at least 12 hours' notice.

I have read and understand the appointment policies.

____________________________________ ________________

Patient/Guardian Date