



Family Chiropractic

To Our Potential New Member:

Thank you for the opportunity to serve you in your health care needs and goals!

To expedite our initial consultation and exam please read carefully ALL the attached paperwork, fill it out as appropriate and sign where indicated.

At your initial visit we will do the following:

1. Review your goal for care, your current health status, your health history and any other pertinent issues you present.
2. Complete a 21 point Chiropractic exam including computerized health scan.
3. If you are presenting with a gift certificate or a special promotional offer, we will BRI EFLY review whether or not Chiropractic care can help you.

On your next visit we will go over the findings and my recommendations in detail. Then we will begin care.

Thank You again for the opportunity to serve you.

Yours In Health,

Leslie G. Kasanoff
Doctor of Chiropractic



*Committed to the Genesis of True Health
In Everyone We Touch.*



Family Chiropractic

Our Mission: Family Chiropractic is committed to the genesis of true health; body, mind and spirit, in everyone we touch through education, leadership and precisely applied chiropractic adjustments.

Office Policy & Financial Agreement

We want to take this opportunity to welcome you to our office. We are committed to empowering you to make wise health choices.

About Your Care:

In this office you are not a 'patient'. To us, a patient is one who has given up control and responsibility and has called on someone to 'fix' them. Chiropractic is not about fixing. It is about releasing your body's innate healing abilities. By accepting care at this office, you are a 'member' of the practice. Much like being the member of a gym, club or organization, there are responsibilities inherent in membership if you want to get optimal results.

So, to get the best results possible from your care:

1. Keep your scheduled appointments and be on time for them.
2. Follow the doctor's recommendations about diet, exercise and stress reduction.
3. Attend our Wellness Orientation Workshop. In this single class, held about twice per month, we will discuss how to find the health you've lost & keep it for a lifetime. By bringing a guest to this event, you will create a partner to support you in your commitment to health. (They will also get a gift certificate for a check-up.)
4. Spread the word: Sharing the possibility of true health with your friends and loved ones is a gift of immeasurable value. Chiropractic can help almost anyone feel better, function better and perform better in many areas of life. Ask us about discount gift certificates and watch our bulletin boards for Wellness Weeks, Children's Month and other specials.

To keep our office running smoothly, we have a few rules:

1. Please give 24 hours notice when rescheduling or canceling appointments. This serves our members, not just us because the doctor is at her peak performance when continually adjusting. Notice will allow us to schedule someone else in that times slot and keep running efficiently. Cancellations with less than 24 hours notice are subject to a cancellation fee.
2. Cash Discounts fees are available for those who keep to the care schedule set up by the doctor and pay at the time of service.
3. Payment is expected at time of service. We accept Visa, MasterCard and ATM cards (also checks and cash). "Cash discounts" are only applicable if you pay at the time of service. There will be additional fees for ALL billed services.
4. If there is any change in your health status while under care, please inform us *before* your next appointment.

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About Insurance:

Insurance is an agreement between the insured (you) and the insurance company. Unless we are a contracted provider with that company, we are **NOT** part of that agreement. Please be advised that you are legally and morally responsible for all charges incurred in this office. We will bill your insurance only **after YOU have called them to ascertain coverage** and filled out the attached form. Any outstanding debts will be billed to you 60 days after the service is rendered. If we are a provider for your PPO, this MAY absolve you of certain responsibilities because of our agreement with the company. If any of this is unclear to you, please ask about it.

Medicare, Medi-CAL, Personal Injury, Workers' Comp:

Note: We are including this regardless of your payment methods as your family & friends may want to know about these policies.

Medicare: We accept assignment on all Medicare covered services. Your CO-payment and payment for any additional services is required at the time of service. See our Medicare Policy sheet for complete details.

Medi-CAL: We do not bill Medi-CAL. However, please talk to us about exchanging services (bartering).

Workers' Comp: We accept a limited number of uncontested, uncomplicated cases. We will review your case in detail before accepting it. If you are covered by Workers' Comp, you can not be billed for any services. We will automatically accept your case if you are already a practice member here and then have an injury.

Personal Injury: If you have "Med-Pay", we will accept your case. If not, we will review the case according to specific criteria to decide if we will accept the case. (Med-Pay is an option on YOUR auto insurance that pays regardless of fault. Payment does not affect your rates. If fault was not yours, the company will re-coup the fees later.)

All Clients read and sign below:

For all cash payment: I understand that fees includes a cash discount that is given at the discretion of this office. I understand that if billing is involved, there will be additional fees.

For all 3rd party pay: I hereby give permission for this office to release any information necessary to obtain payment from a third party. In the case that the office is doing the billing, I also grant permission for checks to be written directly to this office. **I understand that regardless of who does the billing, I am ultimately responsible for all bills incurred in this office.**

I have read and understood the above statements of policy.

Signature & Date:

Family Chiropractic

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care, and when a chiropractor accepts him/her for such care, it is essential that both are seeking and working towards the same goals. Our chiropractic office has only one goal, THE OPTIMIZATION OF YOUR HEALTH POTENTIAL.

This is accomplished by the detection and correction of subluxations.

A subluxation is an alteration in nerve system function. This alteration creates interference to the transmission of mental impulses between the nerve system and the body. Since the purpose of the nerve system is to control and coordinate all body functions, interference to this master system automatically produces improper function in the body. This improper function causes a lessening of the body's innate ability to express its maximum health potential which leads to ill health, pain, symptoms and/or dis-ease.

We do not offer to name, treat or diagnose any of these conditions, symptoms or pain syndromes. We offer instead the detection and correction of subluxations. This allows the INNATE Healing power of the body to work at maximum efficiency to restore, maintain and promote optimal health and well being.

I, _____ having read the above statement, and understand it fully, do undertake chiropractic health care on this basis.

Date _____ Signature _____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Date _____ Signature _____



Acknowledgment Of Special Promotional Fees

I acknowledge that Dr. Kasanoff's initial fee with (coupon/referral card/other: _____) is a special promotional fee.

As such, I understand that any results of any of the tests including examinations, surface electromyography, range-of-motion studies or any other procedures performed on me for the special promotional fee shall not be released to me or to any other doctor or hospital or to any other person or institution unless and until and unless the full and customary fees for the services are paid to Family Chiropractic.

I understand that the doctor will review my results with me and make recommendations but I hereby waive my rights to take physical possession of the originals or copies of the information gained from the aforementioned tests and procedures until the full and customary fees are paid to Family Chiropractic.

Name (print)

Signature

Date

Witness

Waiver of Special Promotional Fee

I hereby waive the special promotional fee for my initial visit. I understand that my insurance will be billed the usual and customary fees for the services that I receive.

Name (Print)

Signature

Date

Witness

Family Chiropractic
138 W Branch St., Suite B
Arroyo Grande, CA 93420
805-481-8821

Acknowledgment:

If you use the discounted fee for your initial examination, the above acknowledgment must be signed first. This assures us that you understand that this is a special Promotional Fee to help you start care **in our office**.

Waiver:

If you've been in an **accident** you must sign the waiver so that we can bill full fees and write the necessary reports for your case based on the examination we are doing today.

If you wish to **bill your insurance company** for future visits, you must sign the waiver so that we can bill them our usual fees and they will have access to exam & results. As a courtesy to you, the special fee will be the maximum co-payment due today.

If you choose to, you may draw a large "X" through the form that you are not using. One of these forms must be signed to complete our examination.

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Family Chiropractic

June 7, 2003

Policy and Information Statement

Purpose: In order to comply with the federal government's new HIPPA (Health Insurance Portability and Privacy Act) Law, Family Chiropractic is informing anyone who obtains services here of the following policies that may result in incidental exposure of your health information to others.

In General: Anyone who works here may be exposed to your confidential health information. Know that they have been trained that all information about you is to be kept in the confines of this office and only discussed as is pertinent to you obtaining care or for billing purposes. Know that any other office or any insurance company we deal with on your behalf is supposed to have similar policies and employee training procedures in place.

Other Exposures:

1. **Sign-in Sheet:** In the near future, we will be instituting a sign-in sheet for all those who have appointments.
 - Reason: This is proof that you were actually here, should that ever be questioned by anyone.
 - Exposure: People signing in after you will be able to see your name.
 - Remedy: There is no remedy offered by this office for this situation.
2. **Open Adjusting Room:** Under most normal circumstances, you will be in an adjusting room with one or two other people.
 - Reason: This is the most efficient set-up.
 - Exposure: Others in the room may hear our conversations about your health or personal issues.
 - Remedies: Several remedies are available for this situation
 - i. You may refuse to discuss anything you don't want to discuss around others.
 - ii. You may request a private room to discuss anything pertinent.
 - iii. You may request that you always be seen in a private room.
3. **Testimonials:** We request information from you to be used for testimonials.
 - Reason: When you get good results from your care and are willing to share this with others, it may help them make the decision to seek care.
 - Exposure: Your name and whatever you say about your condition and care may be shared. With your permission, information such as before and after scans may be exposed.
 - Remedy: You may request that we not expose your name but only share what you say about your care and condition. You may also refuse to furnish testimonial information. We will never use information about you with your name without your permission.

4. **Thank you notes:** If you are referred by someone, they will get a thank you note that will mention your name.
Reason: We choose to acknowledge all acts of generosity.
Exposure: Your name will be revealed to the person who referred you.
Remedy: If you have a strenuous objection to this, we can send a note that does not have your name. Please be advised these notes are usually sent within 24 hours of your initial examination.
5. **Thank you board:** We will sometimes put a "Thank You for your referral" on our white board.
Reason: To acknowledge you and to encourage others to refer.
Exposure: Incidental exposure of your name as someone under care.
Remedy: You may request that we remove it.
6. **Treatment Cards:** Cards with your treatment notes are kept in envelopes in a file in an area that is exposed to others.
Reason: You can pull your card when you enter. Thus allowing you to be able to come back to the adjusting suite and receive your adjustment with a minimum wait time.
Exposure: As others are looking for their card, they may inadvertently see your name on an envelope.
Remedy: If requested to, we can give you a code number that would be on the outside instead of your name.
7. **Faxes to insurance companies, attorneys and other health care providers:**
Reason: We may need to share info by fax with others working on your case.
Exposure: Others not directly involved with your case may see your information when it comes across the fax. Additionally, it is possible for errors in transmission, such as wrong numbers to occur.
Remedy: If you object to this, you would need to supply us with an alternate form of communication, conduct the communication yourself or pay cash for your care so the communication would be unnecessary.
8. **Phone calls to insurance companies:**
Reason: If you have insurance there are times when it may be necessary to contact them by phone about your care.
Exposure: Others who are in our reception areas may overhear information.
Remedy: We make every attempt possible to make these calls when no one is in the reception room or to use another room but incidental exposure may occur. An additional remedy would be for you to do insurance billing yourself.

I _____ do hereby acknowledge having read and understood the above information. I understand that I may request a copy of this form for my records. I consent to the above incidental exposures of my health information. I hereby request that the following remedies be instituted on my behalf: _____

I also understand that I may request a copy of my records and that if I disagree with conclusions in those records, I may request that they be altered. In the event the doctor does not agree with this, I am entitled to insert pertinent information.

Signature _____ Date _____