WELCOME
New Patient & Re-active Forms

Thank you for choosing BACK TALK CHIROPRACTIC. **Please complete all questions.**

Today's Date: _____

Patient Title: (check one)
❑ Mr. ❑ Ms. ❑ Dr. ❑ Rev.
❑ Mrs. ❑ Miss ❑ Prof.

Name: _____ Nick Name_____ Ph. #: H_____ C_____
First MI Last

Address: _____
Street City State Zip

Social Security #: _____ Age:_____ Birth Date: _____ Height: _____ Weight: _____

Employer: _____ Occupation: _____ full/part time Student: full/ part time

Employer Ph. # _____ Gender: M F Marital Status: M S W D Pregnant? Y N Unsure # of Children: _____

Name of spouse/ guardian: _____Emergency Contact: _____ Relationship _____ Ph. _____

E-mail address_____

Primary Care Physician _____**Ph. #** _____

Race: _____ **Multi-Racial**: Y N Unknown **Ethnicity**: Hispanic/Latino Not Hispanic/Latino I choose not to specify

Preferred Language: _____

Verification Question: (choose only one question , then give the answer to that question)

- ❑ What is the name of your favorite pet?
- ❑ What is your favorite movie?
- ❑ What was the make of your first car?
- ❑ In what city were you born?
- ❑ What is your mother's maiden name?
- ❑ When is your anniversary?
- ❑ What high school did you attend?
- ❑ On what street did you grow up?
- ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

How did you hear about us?

Phone Book Internet Billboard Newspaper Friend/ Family Radio Face Book

If a friend, family member, MD, or lawyer referred you, whom may we thank?_____

POLICY HOLDER and INSURANCE INFORMATION

Responsible Party/ Insured's Name: _____ Phone #: _____

Responsible Party/ Insured's Address: _____
Street City State Zip

Responsible Party/ Insured's ID # **AND** SS#: _____DOB_____

Name of Insurance Company: _____ Insured's Group Name or #:_____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

BACK TALK CHIROPRACTIC, PSC
1300 E. New Circle Road Suite 160 • Lexington, KY 40505-4256

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and a over this insurance payment.
A photocopy of this Assignment shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
Dated at Back Talk Chiropractic, PSC this _____ day of _____, 20_____

_____ _____
Signature of Policyholder/ Claimant Office Representative

Advance Beneficiary Notice

Payment Policies

I, _____, currently a patient of Back Talk Chiropractic, PSC located at 1300 E. New Circle Road Suite # 160, Lexington, KY 40505 acknowledge that it has been explained to me that the following services may not be covered by the benefits available to me under the terms of my Health Plan or Insurance policy as named below:

- Manipulation of the Spine
- Examination (E/M)
- Manual Therapy
- Massage
- Physical Medicine (example E-Stim)
- Rehab Therapy (Exercise Training)
- Products (example Pillows, Bands, Supplements)
- Hot/Cold Packs / application
- Durable Medical Equipment
- Axial Decompression
- X-Ray

The reason for this is that:

- This service is excluded from my plan coverage
- This service has not been authorized by my health plan referral to this practitioner
- This service or services may be determined to be a maintenance, preventive, or wellness care procedure
- This service is out of network with above provider
- These x-rays may not be covered by my insurance
- Other:_____

I understand if I have an unpaid balance to Back Talk Chiropractic, PSC *and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.*

In order for Back Talk Chiropractic, PSC *or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that* Back Talk Chiropractic, PSC *and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.*

I agree to pay for these services myself and to make financial arrangements with my practitioner.

Dated,_____(month)_____(day), 20_____.

_____(Patient Signature)

HIPPA CONSENT FORM

Consent for Purposes of Treatment, Privacy Acknowledgement, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Back Talk Chiropractic, PSC** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Back Talk Chiropractic, PSC**.
I understand that diagnosis or treatment of me by **Dr. Tamera Tolson** may be conditioned upon my consent as evidenced by my signature on this document.
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Back Talk Chiropractic, PSC** is not required to agree to the restrictions that I may request. However, if **Back Talk Chiropractic, PSC** agrees to a restriction that I request, the restriction is binding on **Back Talk Chiropractic, PSC** and **Dr. Tamera Tolson**.
I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Tamera Tolson** or **Back Talk Chiropractic, PSC** has taken action in reliance on this consent.
My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
I understand I have a right to review **Back Talk Chiropractic, PSC**'s Notice of Privacy Practices prior to signing this document. The **Back Talk Chiropractic, PSC**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Back Talk Chiropractic, PSC**. The Notice of Privacy Practices for **Back Talk Chiropractic, PSC** is also provided **at the front desk** and on the **[name of covered health care provider]**'s website at [website address where NPP is posted.] This Notice of Privacy Practices also describes my rights and the **Back Talk Chiropractic, PSC '**s duties with respect to my protected health information.

Back Talk Chiropractic, PSC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Back Talk Chiropractic, PSC**'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Guardian Date

_____

Name of Patient or Guardian Relationship to Patient

- ❑ This is to acknowledge that I have been given the opportunity to review **Back Talk Chiropractic, PSC, Notice of Privacy Practices.**

  I understand that I have the right to request a personal copy of this office's **Notice of Privacy Practices**.

Initial _____

HIPAA Authorization Form

Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, _____, hereby authorize _____ to disclose this protected health information, copy of files, x-rays, exams, and all reports to Back Talk Chiropractic, PSC 1300 E. New Circle Road Suite # 160 Lexington, KY 40505.
This authorization shall be in force and effect until one (1) year from date of signature at which time this authorization to use or disclose this protected health information expires.
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Denise Crosby at 1300 E. New Circle Road Suite # 160 Lexington, KY 40505. I understand that a revocation is not effective to the extent that Back Talk Chiropractic, PSC has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
Back Talk Chiropractic, PSC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

I have signed this consent form and have been made aware of the practice's **"NOTICE OF PRIVACY PRACTICES"**. **This statements included in this authorization are binding.**

_____

Patient or Guardian Signature Date

_____ _____

SSN DOB Office Representative Date