

**Patient Information**

Please complete the all areas of the top box, if a field does not apply please put N/A in that space. If you have more than primary insurance please continue to the second and or third box, filling in that insurance information as well, it will help us to more accurately determine your benefits.

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Home Phone: \_\_\_\_\_ Alt/Work Phone: \_\_\_\_\_  
Marital Status M  D  S  W  Children, Ages: \_\_\_\_\_ Spouses name: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Would you like a text reminder of your appts? Yes/No  
Cell Phone Service Provider: \_\_\_\_\_ Email: \_\_\_\_\_  
Who referred you to us? \_\_\_\_\_ How else did you hear about us? \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Primary Insurance Name:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy/ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Patient's Chief Complaint: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Insured SS#/ID# \_\_\_\_\_

**Secondary Insurance**  
Insured: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Insured SS#/ID#: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Group#: \_\_\_\_\_ Policy/ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Third Insurance**  
Insured: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Insured SS#/ID#: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_ Phone: \_\_\_\_\_

# Ingram Health Care, P.C.

## FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have health insurance, we want to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and understanding of our payment policy.

### **HMO/PPO/MAJOR MEDICAL**

Our Doctors participate in a number of HMO and PPO networks. **It is your responsibility to verify that the doctor you are seeing is in "network" and any information your insurance carrier may need prior to your first office visit such as a referral.** We must have the referral prior to your first appointment. Please verify this by calling the "800" telephone number on your group insurance card or check with your employer as to how to obtain this information. If no referral is received and your insurance carrier denies claim because of no referral, payment for services rendered is **payable by you**, the patient and not the insurance carrier. This also applies if you terminate insurance coverage, or if you change to a new insurance carrier.

**Co-pays are collected on each visit.** If you are not insured by one of the participating HMO or PPO insurance companies, payment will be collected according to your plan's out-of-network benefits. We accept cash, checks, MasterCard, Visa, and Discover.

### **CASH**

If you carry no medical coverage, you are considered a cash patient. Therefore payment in full is required at the time services are rendered.

### **PHYSICAL THERAPY**

Ingram Health Care now has **Two Licensed Physical Therapists** on staff. All Physical Therapy **requires a Doctor's prescription**, so please bring the prescription to your first office visit, or fax it to us **prior to your visit**, our fax # is (903)567-5938.

### **MEDICARE**

We accept Medicare assignment and will bill Medicare for you. If you have any supplemental insurance, or secondary insurance please bring this information with you to your appointment. You may be responsible for a portion of your charges, as well as your Medicare Deductible. Most importantly about Medicare, they only cover/accept chiropractic manipulation/adjustments from a chiropractor. Medicare limits visits based on diagnosis and what **THEY** deem "**medically necessary**". **THEY DO NOT COVER MAINTENANCE VISITS.** Your first visit they require an examination to form a diagnosis and treatment plan; however, they do not cover the examination, nor x-rays or any therapy other than a spinal manipulation for a chiropractor. If modalities are needed, you may obtain a **referral** for physical therapy and Medicare **will cover/accept** most therapies for our **Physical Therapists**. Please bring a **Doctor's prescription** with you on your first visit, so that we may correctly bill your insurance carrier. If for any reason Medicare does not cover certain modalities, you the patient will be responsible for payment on dates for services rendered.

## **MEDICAID**

We accept Medicaid assignment and will bill Medicaid for you. If you have any supplemental insurance, or secondary insurance please bring this information with you to your appointment. You may be responsible for a portion of your charges, as well as your Medicaid Deductible. Most importantly about Medicaid, they only allow 12 visits a year, and only cover/accept chiropractic manipulation/adjustments from a chiropractor. Your first visit they require an examination to form a diagnosis and treatment plan; however, they do not cover the examination, nor x-rays or any therapy other than a spinal manipulation for a chiropractor. If modalities are needed, you may obtain a referral for physical therapy and Medicaid will cover/accept most therapies for our Physical Therapists. Please bring a Doctor's prescription with you on your first visit, so that we may correctly bill your insurance carrier. If for any reason Medicaid does not cover certain modalities, you the patient will be responsible for payment on dates for services rendered.

## **WORKER'S COMPENSATION**

If you are being treated for a work-related injury (Worker's Compensation), we must have approval from your adjuster PRIOR to your appointment. We will need the following information: insurance carrier, address, telephone number, adjuster's name and the claim or case number.

## **PERSONAL INJURY/PERSONAL INJURY PROTECTION**

If treatment is sought due to a motor vehicle accident or other personal injury, we do accept letters of protection and your Personal Injury Protection Plan. We must have all the following information PRIOR to your appointment. L.O.P. (Letter of Protection): Lawyer's Name and Phone Number. P.I.P. (Personal Injury Protection): Insurance Carrier, Address, Telephone Number, Adjuster's Name, and Claim Number. We do not accept third party insurance.

## **SCHOOL INSURANCE**

If your injury occurred on school campus, you must bring claim form completed by the appropriate school official. This claim form should include details of the accident and the name and address of the school's insurance company.

**There will be a \$30 charge for all returned checks.**

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered.

**I HAVE READ AND COMPLETELY UNDERSTAND THE FINANCIAL POLICY OF THE INGRAM HEALTH CARE CLINIC.**

\_\_\_\_\_  
Print Patient Name and/or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient and/or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Finance Counselor /or Front Desk

\_\_\_\_\_  
Date

# **Informed Consent for Examination and Treatment**

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I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period \_\_\_\_\_.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or authority if not signed  
By patient

\_\_\_\_\_  
Witness

# HEALTH CARE AUTHORIZATION FORM

Patient's Name \_\_\_\_\_

Patients SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **INGRAM CHIROPRACTIC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

## **SPECIFIC AUTHORIZATIONS**

- I give permission to **INGRAM CHIROPRACTIC** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
  
- (OPEN ROOM AUTHORIZATION)**  
I give **INGRAM CHIROPRACTIC** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
  
- By signing this form you are giving **INGRAM CHIROPRACTIC** permission to use and disclose your protected health information in accordance with the directives listed above.

## **EXPIRATION**

The Authorization shall expire on the following date: \_\_\_\_\_

## **RIGHT TO REVOKE AUTHORIZATION**

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **KRISTOFER INGRAM, DC**. The written notice must contain the following information:

1. Your Name
2. Your Social Security Number
3. Your Date of Birth
4. A clear statement of your intent to revoke this AUTHORIZATION
5. The Date of your Request
6. Your Signature.

The revocation is not effective until the Privacy Official receives it.

INGRAM CHIROPRACTIC requests this AUTHORIZATION for its own use/disclosure of PHI.  
(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **INGRAM CHIROPRACTIC** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

- \* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU \* •

Print Name of Patient \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Personal Representative \_\_\_\_\_

Description of Representative's  
Authority to Act for Patient: \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Please read carefully:**

Please check the appropriate response. If you are not sure, check the "?" box.

- | NO  | YES | ?   |   |
|-----|-----|-----|---|
| ( ) | ( ) | ( ) | Do you have a past history of cancer?                                   |
| ( ) | ( ) | ( ) | Have you had any unexplained weight loss?                               |
| ( ) | ( ) | ( ) | Does your pain fail to improve with rest?                               |
| ( ) | ( ) | ( ) | Are you over 50 years of age?   |
| ( ) | ( ) | ( ) | Failure to respond to a course of conservative care (4-6 weeks)?        |
| ( ) | ( ) | ( ) | Have you had spinal pain greater than 4 weeks?                          |
| ( ) | ( ) | ( ) | Prolonged use of corticosteroids (Such as organ transplant Rx)?         |
| ( ) | ( ) | ( ) | Intravenous drug use?   |
| ( ) | ( ) | ( ) | Current or recent urinary tract, respiratory tract or other infection?  |
| ( ) | ( ) | ( ) | Immunosuppression medication and/or condition?                          |
| ( ) | ( ) | ( ) | History of significant trauma?  |
| ( ) | ( ) | ( ) | Minor trauma in a person greater than 50 years old?                     |
| ( ) | ( ) | ( ) | Do you have osteoporosis (weak bones)?                                  |
| ( ) | ( ) | ( ) | Are you over 70 years old?  |
| ( ) | ( ) | ( ) | Any history of prolonged use of corticosteroids?                        |
| ( ) | ( ) | ( ) | Acute onset urinary retention or overflow incontinence (wet underwear)? |
| ( ) | ( ) | ( ) | Loss of anal sphincter tone or fecal incontinence (bowel accidents)?    |
| ( ) | ( ) | ( ) | Sadal anesthesia (numbness of the groin region)?                        |
| ( ) | ( ) | ( ) | Global or progressive muscle weakness in the legs (legs give out)?      |

Comments: \_\_\_\_\_

\_\_\_\_\_

Patient: \_\_\_\_\_