

Ingram Healthcare Patient Registration

Patient Information

Name _____

Address _____

City/State/Zip _____

Home Ph _____

Wk Ph _____

Cell Ph _____ DOB _____

E-Mail _____

SSN _____

Single ___ Married ___ Other ___ Spouse Name _____

Hm/Wk Ph _____

Employed ___ FT Student ___ PT Student ___ Other ___

Employer _____

Address _____

Emergency Contact _____ Ph _____

Referred By _____ Family Physician _____

Policyholder Information

Policyholder Name _____

Insurance Name _____

Policy # _____

Group# _____

INS # _____

Policyholder DOB _____

Secondary Insurance Information

Policyholder Name _____

Insurance Name _____

Policy # _____

Group # _____

INS # _____

Third Insurance Information

Policyholder Name _____

Insurance Name _____

Policy # _____

Group # _____

INS # _____

Thank you for choosing Ingram Healthcare. All information given is strictly confidential and will not be released to anyone without written consent.

Signature (Patient, Parent or Guardian)

Date

Ingram Healthcare

Financial Policy

Thank you for choosing Ingram Healthcare for your chiropractic care. We are committed to providing the highest quality chiropractic care possible. We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. We hope that by providing you with our policies in advance we can prevent misunderstanding and frustration. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

Full payment is due at the time service is rendered. We accept cash, check, or Visa/MasterCard/Discover.

Insurance- As a courtesy, we get a basic breakdown of your benefits from your insurance company so that we can offer you an estimate of your benefits. The estimated percentage not covered, including any deductible and co pay, is to be paid at the time service is rendered.

Our office files insurance for our patients as a courtesy. Please keep in mind your contract is between you and the insurance company. Your involvement in the process of providing us with the proper information, and you being proactive in knowing your plan, will help us maximize your benefits to their full potential.

Please be aware that you are fully responsible for understanding your plan and exclusions and how it relates to your chiropractic procedures. It is your responsibility to be sure that we are a participating (in network) provider. It is also your responsibility to ensure that if your plan requires a referral that your primary care provider, provides us with all referral information prior to your visit. At any time, if you have any questions regarding your plan as it relates to your treatment, we will be happy to try to answer to the best of our knowledge. However, it is your responsibility to verify and determine coverage of service with your insurance company. If your insurance does not cover procedures as estimated, the portion not covered is your responsibility.

School Insurance- Our office DOES NOT accept school accident insurance. Payment is due at the time service is rendered. We will provide you with everything necessary to be reimbursed.

Medicare- Our office will bill Medicare for you. If you have secondary insurance or Medicare supplement insurance and would like for us to file that as well please provide our office with this information. Please keep in mind that Medicare requires an examination to determine diagnosis, although they DO NOT cover this visit. Medicare DOES NOT cover x-rays or any other therapy. Medicare will ONLY cover spinal manipulation/adjustment appointments. The estimated percentage not covered, including any deductible and co pay is your responsibility and is due at the time service is rendered.

Medicaid- Our office does accept Medicaid. A copy of your current Medicaid card is required prior to any visit. Medicaid requires an examination to determine diagnosis, although they DO NOT cover this

visit. Medicaid will ONLY cover spinal manipulations/adjustment appointments, and only cover 12 visits per year. Keep in mind that if for any reason Medicaid does not cover any procedures you will be responsible for any balance on your account.

Personal Injury/Personal Injury Protection- If you are being seen due to a motor vehicle accident we do accept Personal Injury Protection through your auto insurance. We will need the name of your auto insurance company, the adjuster's name, address, phone number and a claim number. We do not accept third party insurance. We do also accept letters of protection if you have a lawyer handling your motor vehicle accident. We will need a LOP (Letter of Protection) from your lawyer's office including the lawyers name, address, and phone number prior to your visit.

Cancelations- Please be aware that our office charges \$20 for not showing up for an appointment, and for canceling without 24 hour notice for all spa, AAT, doctor consults, and Club Reduce consults.

I have read, understand, and agree the Financial Policy.

Printed Patient Name	Patient, Parent, Legal Guardian Signature	Date
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Printed Name Legal Guardian _____

Address _____

City/State/Zip _____

Phone # _____

Ingram Healthcare

921 W. Dallas St.

Canton, TX 75103

Phone: 903-567-5579

Fax: 903-567-5938

Ingram Healthcare Notice of Privacy Practices

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please use the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of

this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses, or disclosures, in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health- Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert to a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You

must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0 for each page, and \$20 per hour for staff time to locate and copy your health information, and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (E-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S Department of Health and Human Services. **Contact the Administrator listed below for more information.**

Kristofer Ingram, DC, 921 W. Dallas St. Canton, TX 75103 Phone (903) 567-5579 Fax (903) 567-5938

ACKNOWLEDGE OF RECEIPT/REVIEW OF NOTICE OF PRIVACY PRACTICES

I, _____, have received/reviewed a copy of this office's Notice of Privacy Practices.

Printed Name _____

Signature _____

Date _____

For Ingram Health Care Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Name of office personnel: _____

****It is your legal option to not sign this acknowledgement, however, our policy states that if we do not have this signed acknowledgement from you, we will not be able to provide you with our services.****

