Bellevue Chiropractic Centre

Improving Function, Improving Life

Dr. William Walsh, DC and Dr. Bridget Walsh, DC

Clinic Policies

We believe that a clear definition of our clinic policies will allow us both to concentrate on the most important issue – your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

Patient Payment Policy

Payment is expected at the time of service. Most insurance policies cover chiropractic care. We will be happy to file your primary and secondary insurance claims as a service to you. We cannot take responsibility for what your health insurance will or will not cover. Your co-pays and deductible payment are expected at the time of service. However, the patient's health needs are paramount, and, upon your request, our staff will arrange for payment plans if need be. Properly documented Worker's Compensation and auto accident claims are not required to be paid at the time of service.

Appointments

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late.

Emergencies or After Hour Calls

In case of an emergency, you may contact the office for a special appointment any time during regular office hours. If you, a friend, or family member requires after hours or weekend assistance, you may call the clinic for special assistance.

Who is responsible for your bill?

___ Self ___Spouse ___Parent ___Insurance ___Worker's Comp ___Auto Insurance ___Medicare ___Medicaid

We welcome you to ask the doctors or staff about questions about your account or any aspect of your care. Getting you well is our primary concern.

I have read the Bellevue Chiropractic Centre Policies and will honor them.

_____ _____

Patient Signature Date

Insurance Information

Insurance Company Name _____ Phone Number _____

ID# _____ Group# _____

Name of Insured _____ Relationship _____self _____spouse _____parent

Insured's DOB _____ Insured's SS# _____

Insured's Phone # _____ Insured's Employer _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Bellevue Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctors to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

700 Lincoln Ave, Bellevue, PA 15202 | Phone: 412-766-5577 | Fax: 412-766-4350
Web: www.bellevuepachiro.com | Email: bellevuepachiro@gmail.com

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Consent for Use or Disclosure of Health Information

While the Health Insurance Portability & Accountability Act (HIPPA) requires us to give you this disclosure, please understand that we are very concerned with protecting your privacy and will always respect the privacy of your health information. Bellevue Chiropractic Centre may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding to us. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Upon request, you may receive a copy of this authorization. This authorization will expire seven years after the date on which you last received services from us.

I authorize Bellevue Chiropractic to use or disclosure my health information in the manner described above.

_____	_____	_____
Patient Name Printed	Patient Signature	Date
_____	_____	_____
Personal Representative Printed	Personal Representative Signature	Description (parent, guardian, etc)

Bellevue Chiropractic Representative: _____

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Informed Consent in Doctor-Patient Relationship

Chiropractic

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, and physical and spinal conditions.

Analysis

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of spinal conditions. When spinal conditions are found, chiropractic adjustments and/or ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment and motion allows nerve transmission throughout the body and gives the body an opportunity to use its recuperative powers. Due to the complexities of nature, no doctor can promise you specific results.

Diagnosis

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not internal medicine specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if s/he has any concerns as to the nature of their total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, in coming to a doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment and or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical deficits, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if s/he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever s/he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of chiropractic services is to promote natural health through the care and correction of spinal function. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond different to the same chiropractic care. Many medical chiropractic cases may be controlled or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all the problems. Both have made great strides in alleviating pain and controlling disease.

Please discuss any questions or problems with the doctor before signing this statement of policy. I have read and understand the foregoing.

_____ _____

Patient Signature Date

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Informed Consent for E-mail Appointment Reminder

• I consent to Bellevue Chiropractic Centre contacting me by e-mail for the purpose of receiving appointment reminders.

• I acknowledge that appointment reminders by e-mail are an additional service, and the responsibility of attending appointments or changing them still rests with me. I understand that if I am not able to keep an appointment I will phone Bellevue Chiropractic Centre within 24 hours notice to change the appointment.

• E-mails are generated using a secure facility, but I understand that they are transmitted over a public network onto a personal device and, as such, may not be secure. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text or e-mail may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in e-mails may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

• All patients have the right to revoke this consent and have this service stopped. If you no longer wish to receive these reminders please notify our office at (412) 766-5577.

• The automated service does not offer a reply facility to enable patients to respond to e-mails directly.

• I agree to advise the practice if my e-mail changes or if this e-mail is no longer in my possession.

The e-mail address that I authorize to receive appointment reminder e-mails:

_____

I consent to receiving appointment reminders from Bellevue Chiropractic Centre at the e-mail provided.

_____

Patient Name (print)

_____ _____

Patient/Guardian Signature Date

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Web: www.bellevuepachiro.com | Email: bellevuepachiro@gmail.com

Confidential Patient Health Record

Personal History

Name: first _____ middle _____ last _____
Address: _____ City, State, Zip _____
Email: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Business Employer: _____ Type of Work: _____
Social Security Number: _____ DOB: _____ Age: _____
Sex: F M *Circle one*: Single Married Widowed Divorced Separated
Spouses Name: _____
Spouse's SS#: _____ Spouse's DOB: _____
Spouse's Business Employer: _____ Type of Work: _____
Spouse's Business Phone Number: _____ Spouse's Cell: _____
Name & Ages of Children: _____
Name & Number of Emergency Contact: _____ Relationship: _____
Who referred you to our office? _____

Current Health Conditions

Purpose of this appointment: _____
Have you seen other doctors for this condition? ☐ yes ☐ no Who? _____
Type of treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? _____
Is this condition: ☐ job related ☐ auto accident ☐ home injury ☐ fall ☐ other: _____
Date of accident: _____ Time of accident: _____
Have you made a report to your accident to your employer? ☐ yes ☐ no
Drugs you now take: ☐nerve pills ☐pain killers/muscle relaxers ☐blood pressure medicine
☐insulin ☐other:_____
Do you wear a shoe lift? ☐ yes ☐ no
Do you suffer from any condition other than the one you are consulting us about today? _____
_____

Past Health History

Major surgery/operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia
☐ Back Surgery ☐ Broken Bones ☐ Other _____
Major accidents/falls: _____
_____
Hospitalization (other than above): _____
_____
Previous Chiropractic Care: ☐ None ☐ Doctor's name and date of last visit: _____

Check any of the following diseases you have had:

☐Pneumonia	☐Pleurisy	☐Polio	☐Rheumatic Fever	☐Tuberculosis
☐Small Pox	☐Chicken Pox	☐Mumps	☐Measles	☐Whooping Cough
☐Arthritis	☐Eczema	☐Diabetes	☐Epilepsy	☐Cancer
☐Anemia	☐Mental Disorders	☐Lumbago	☐Heart Disease	☐Thyroid
☐Influenza				

Family History

The following have the same or similar problem as I do:
☐Mother ☐Father ☐Brother ☐Sister ☐Spouse Child

Check any of the following you have had in the past 6 months:

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

CVR
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Gastro-Intestinal
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Discolored Urine
- ☐ Painful/Excessive Urination

Female/Male
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

HIV Positive
☐ Yes ☐ No

Intake
☐ Coffee ☐ Tea
☐ Alcohol ☐ Cigarettes

Females Only:

Are you Pregnant? ☐ Yes Due Date: _____ When was your last period? _____
☐ No Please sign the following waiver.

I hereby notify all concerned that I neither suspect nor know positively at this time that I may be or am pregnant. I release this clinic from any and all damages arising from any and all procedures of a diagnostic or treatment nature with reference to the possibility of pregnancy.

_____ _____
Patient Signature Date

I hereby authorize the Doctor(s) to treat my condition as s/he deems appropriate through use of manipulation throughout my spine.

Patient Signature _____ Date _____

Parent or Guardian's Signature if Patient is under the age of 18 _____

Spouse or Personal Representative Signature if Patient is unable to sign _____