Mulholland Chiropractic Center, LLC
2020 Abbott Rd, Suite 2, Anchorage, AK 99507 907-770-5700

Patient Name: _____ DOB_____ Date _____

Patient Information

Legal First Name: _____MI: _____ Last Name: _____

Nickname or Preferred First Name: _____

Physical Address:_____Apt: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____Apt: _____

City: _____ State: _____ Zip: _____

Marital Status: S M W D Spouse Name: _____

Language: English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean ____
French _____ German _____ Russian _____ Other_____

Race: White _____ American Indian or Alaska Native _____ Asian _____
Native Hawaiian/Other Pacific Islander _____ Black or African American _____
Hispanic or Latino _____ Other_____ Decline to Answer _____

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Decline to Answer _____

Gender: Male Female Decline to Answer

DOB: _____ Home Phone: _____ Work Phone:_____

Cell Phone: _____ Cell Carrier: _____

Contact Preference: Hm _____ Wk _____ Cell _____ Email _____ Postal Mail _____

Email hm: _____ Email wk: _____

Emergency Contact:_____ Phone Number: _____

Occupation: _____ Employer: _____

Employer Address: _____

Whom may we thank for referring you to our office? _____

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Patient Name: _____ DOB_____ Date _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Subscriber information

If you have your own individual plan or a plan through your employer, you would be the primary subscriber. If, on the other hand, you have insurance through your parents, spouse, or registered domestic partners' Employer, your parents/spouse/domestic partner who is covering you as a dependent under his or her health insurance plan would be the primary subscriber.

Primary Insurance

Are you the primary Subscriber? Yes No

If no, who is primary Subscriber? Spouse Parent Employer Other _____

Subscriber Name: _____ Subscriber DOB: _____

Ins Co: _____

Policy # _____ Group # _____

Ins Co Phone Number (on the back of the card) _____

Secondary Insurance

Are you the primary Subscriber? Yes No

If no, who is primary Subscriber? Spouse Parent Employer Other _____

Subscriber Name: _____ Subscriber DOB: _____

Ins Co: _____

Policy # _____ Group # _____

Ins Co Phone Number (on the back of the card) _____

Third Insurance

Are you the primary Subscriber? Yes No

If no, who is primary Subscriber? Spouse Parent Employer Other _____

Subscriber Name: _____ Subscriber DOB: _____

Ins Co: _____

Policy # _____ Group # _____

Ins Co Phone Number (on the back of the card) _____

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Your name: _____ Date: _____

Please briefly describe the symptom, problem, condition, diagnosis or reason for your visit:

_____

_____

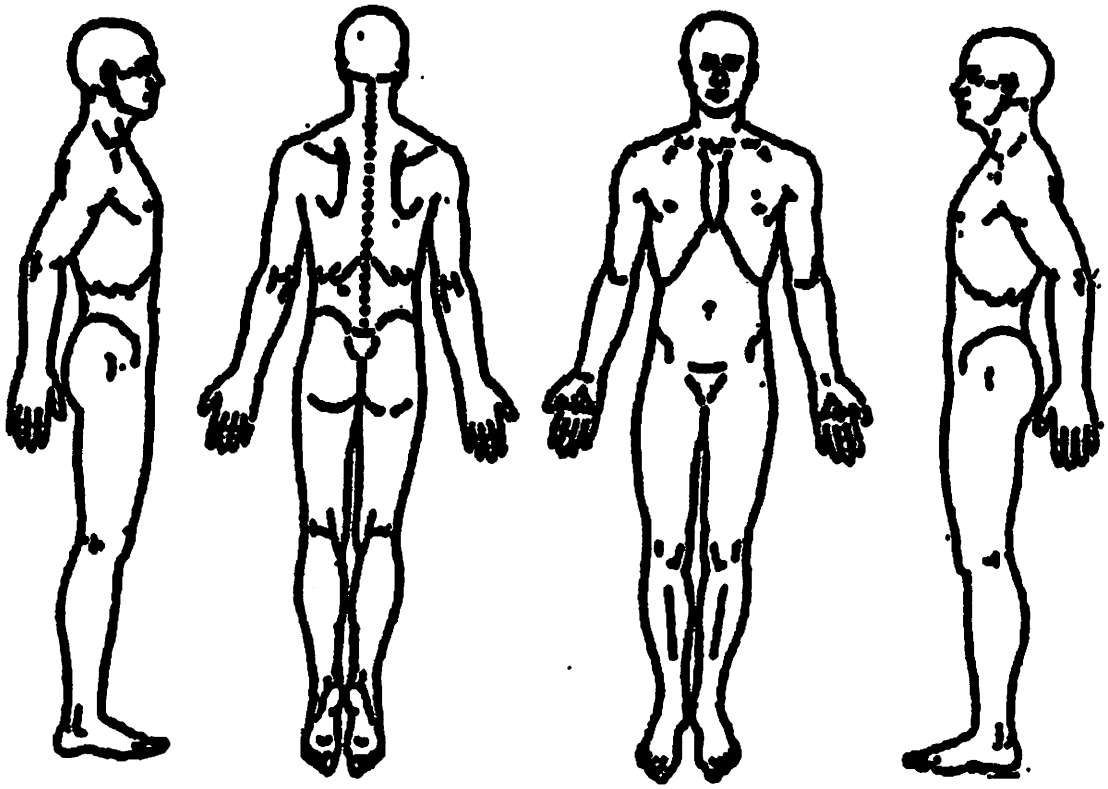
_____

_____

_____

_____

This is called a pain diagram. Please circle the areas of your complaints on the diagram(s) below and label them number one (1) the primary complaint or most severe complaint, number two (2) the second most severe complaint, and count up from there. Bring this with to your initial appointment. Your Doctor will review these with you and will have more specific questions about these complaints.



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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Your Healthcare Information is Private

We understand that information we collect about you and your health is personal. Keeping your healthcare information private is one of our most important responsibilities.
The law says:
1. We must keep your healthcare information from others who do not need it.
2. You may ask us not to share certain healthcare information, even though sometimes we may not be able to agree to your request.
We are committed to protecting your healthcare information and following all laws regarding the use of that information. You have the right to discuss with your privacy officer any concerns you may have about how your healthcare information is shared.

Who Sees and Shares My Health Information?

Your healthcare givers, such as nurses, doctors, and others may see, use and share your healthcare information to determine your plan of care. This use may cover healthcare services you had before now or may have later. We may review your healthcare information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your healthcare and being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How Does This Affect Payment Programs?

We may share your healthcare information with health plans, insurance companies, or government programs which may help you get your benefits or may assist you in paying for your healthcare services.

May I See My Health Information?

In most cases, you may see your healthcare information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. If you think some of your healthcare information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your healthcare information from us. You may ask us for a list of where we sent your healthcare information.

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What If My Healthcare Information Needs to Go Somewhere Else?

You may ask to have your healthcare information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your healthcare information to go to them. The authorization form tells us what, where, and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing. We may charge a small amount for copying costs. Note: if you are younger than 18 years old and, by law, you are able to consent for your own healthcare, then your healthcare information is kept private from others unless you sign an authorization form.

Could My Health Information Be Released without My Authorization?

We follow laws that tell us when we have to share healthcare information, even if you do not sign an authorization form. We always report:
1. Reportable infectious diseases and birth defects;
2. Reactions or problems with medications or defective medical equipment;
3. To the police when required by law;
4. When the court orders us to;
5. To the government to review how our programs are working;
6. To the provider or other insurance company who need to know if you are enrolled in one of our programs;
7. Birth, death and immunization information;
8. To the federal government when they are investigating something important to protect our country;
9. Abuse, neglect and domestic violence, if related to child protection or vulnerable adults;
10. To workers compensation for work-related injuries;
11. We may also share healthcare information for permitted research purposes and serious threats to public health or safety.

May I Have a Copy of This Notice?

This notice is yours, and you may ask for another copy at any time. If there are important changes to this notice we will get a new copy to you on your next visit.

Questions or Complaints?

If you have questions or feel your privacy rights have been violated, you can contact your privacy officer by writing to him at the address above, attention Privacy Officer. Your healthcare services will not be affected by any concerns brought to him or her.

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Financial Information and Authorization

Regular Insurance

Many insurance companies now provide coverage for chiropractic services, and hopefully yours is one of them. As a courtesy to our patients, we will bill your insurance company, provided we receive a completed claim form and verify that your policy provides for your coverage. If you haven't done so already, you can assist us by providing the name and phone number of your insurance company, as well as your policy number and subscriber number. Remember however that insurance coverage usually has a deductible amount that must be met, as well as a percentage "co-pay" that is your responsibility. This must be paid by you as services are rendered. If these present a hardship to you, we can make arrangements for affordable payments which can be made concurrent with your care. Also, remember that your insurance policy is a contract between you and the insurance company, and we are not a party to that contract. Questions about coverage, benefits, deductibles or others should be addressed by you directly with your insurance company. We cannot negotiate for you, but we will gladly assist you by providing all necessary paperwork to process your claim.

Workers Compensation and Personal Injuries

These cases are handled differently than others because they either have special laws that apply, have additional people that must be informed, or have unique reporting requirements for the doctor, patient, or employer. We gladly accept these cases, and will do everything we can to comply with these special requirements, but it is important that you do your part as well. We cannot accept your case as a WC/PI case until an appropriate accident report is filled out and submitted to us, a claim number is provided and coverage is verified. Since there are typically other parties involved or responsible, it is also very important that you, the patient, do everything in your power to comply with your treatment recommendations from your doctor. Any patient that does not comply with the doctor's recommendations for care may be dismissed from being a WC/PI account, and will be responsible for their balance. In that case, we can certainly make arrangements to bill your regular insurance, or set up an affordable monthly payment plan for you.

Medicare / Medicaid / Managed Care

These are corporate or government sponsored programs and have special requirements both for qualifications and record keeping, as well as payment. Not all doctors participate in these programs, so if you think you are covered under one of these programs, you must discuss this with the billing staff as well as your doctor before we can accept you as a Medicare/Medicaid/Managed Care patient.

Special Arrangements

Not everyone has the benefit of insurance or other assistance programs, and even if you do, the deductibles and co-pay portions can be substantial. We understand that these can be a hardship for you. To whatever extent possible, we don't want financial considerations to be a barrier to your getting the chiropractic care you need. Our billing staff will gladly explain these options to you at your convenience.

If you have insurance, we will need a copy of your Insurance Card, Claim Number, or completed Accident Report Form.

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Authorization

The attorney(s) and/or insurance carrier(s) are hereby authorized and directed to pay directly to Mulholland Chiropractic Center, LLC any and all money due on my account(s), and that money is to be paid directly to Mulholland Chiropractic Center, LLC from any proceeds or settlement(s) made on my behalf. I authorize Mulholland Chiropractic Center, LLC to release any information necessary and appropriate to recover those benefits.

I also agree that I'm responsible for the full amount of charges from Mulholland Chiropractic Center, LLC regardless of whether my condition is covered or not, or if for any reason the insurance carrier(s) or responsible party(s) refuse to pay my claim. I understand that Mulholland Chiropractic Center, LLC has the right to file a lien according to law, and I authorize Mulholland Chiropractic Center, LLC to do so to insure that payment is directed as outlined above. A copy of this agreement is as valid as the original.

By signing this I also acknowledge that a copy of our Notice of Privacy Practices has been made available to me and I understand my privacy rights.

_____

Patients Name (First, Middle, Last)

_____ Date: _____

Patient/Guardian Signature

Mulholland Chiropractic Center, LLC
2020 Abbott Rd, Suite 2, Anchorage, AK 99507 907-770-5700

Financial Policy

In keeping compliant with recent federal regulations, we have developed this financial policy. Below are the descriptions of the various forms that financing can be made for your care at our office.

1. Published fees. The fees for any of our services are available from our front desk staff upon request. We do everything we can to make our fees competitive and affordable. While a person is always encouraged to keep their account current, we understand that this can occasionally be difficult. We also offer financing options and payment plans so that the cost of healthcare can be easier on your budget.

2. Discount medical plan organizations. You may be fortunate enough to have one of these available to you. These are things like insurance plans and other entities that have pre-negotiated fee schedules. Some of these we participate with, and with some we are out of network. We currently participate with Blue Cross and Aetna. What that means is that they publish their reimbursement schedule, and we accept that reimbursement as payment. You may also have deductibles and copayments to make which are part of your plan. We are not allowed to alter those on your behalf as that is a contract between you and your insurance company. We also participate with ChiroHealth USA, or CHUSA. This is a discount medical plan that you can subscribe to, similar to buyers' clubs like Costco or Sam's Club, which entitles you to pre-negotiated discounts as well as capped amounts on a variety of services available at our office.

3. Regulated plans. These include plans regulated by law, such as Medicare, Medicaid, and the Veterans Administration. We currently do accept these cases, but they do have very specific inclusions and exclusions. While this may cover a significant portion of your care, it may not cover all of your required services such as evaluations, x-rays or therapies. In those cases you would be responsible for the balance. Fortunately many times you can blend your reimbursement plans with things like other insurance policies/retirement plans or other discount medical plans such as CHUSA, or even with hardship plans.

4. Assistances cases, also known as hardships. Ultimately, it is our goal that no one would be denied their healthcare because of financial concerns. Under assistance cases we have much more flexibility with financial plans, but they do come with responsibilities on your part. You will be required to fill out an assistance form and verify your assistance status. This will need to be updated regularly. Once this is established we can then establish a sliding fee scale appropriate to your level of assistance.

In any of these cases, please feel free to ask any of our helpful staff for details as to how these may apply to you. Regardless of the type of financing that applies to you, we have affordable payment plans available for the balance. Our goal is to make your treatment at our office as easy and affordable for you as possible.

Mulholland Chiropractic Center, LLC
2020 Abbott Rd, Suite 2, Anchorage, AK 99507 907-770-5700

Consent to Treat

I _____ give Mulholland Chiropractic Center, LLC permission to treat me.

Mulholland Chiropractic Center shall have the authority to:

- give chiropractic treatments, medical advice, as well as use ancillary therapies such as ultrasound, electrical stimulation, traction, exercises, and other therapies as needed for the individual patient.

- take x-rays and/or order tests as needed.

This grant of authority shall begin the date signed, and shall remain effective until terminated with written notice.

_____ _____
Signature Date

Consent to Treat a Minor

I _____ as a parent or guardian give Mulholland Chiropractic Center, LLC permission to treat the following child(ren):

_____
_____
_____
_____

Mulholland Chiropractic Center shall have the authority to:

- give chiropractic treatments, medical advice, as well as use ancillary therapies such as ultrasound, electrical stimulation, traction, exercises, and other therapies as needed for the individual patient.

- take x-rays and/or order tests as needed.

This grant of authority shall begin the date signed, and shall remain effective until terminated with written notice.

_____ _____
Parent/Guardian Signature Date

Mulholland Chiropractic Clinic
2020 Abbott Rd. Suite 2
Anchorage, AK 99507

Patient Name:_____

DOB:_____

Mulholland Chiropractic Clinic Massage Therapy Policy

Listed below are the polices that will be followed when scheduling a massage or manual therapy appointment. This is to help ensure that our patients and therapists times are utilized to the fullest which will result in the most effective treatment possible.

1. Please provide at least 24 hours notice of a cancellation or rescheduled appointment. Leaving a message on the office phone during the night is sufficient.

2. Please be a few minutes early if possible for your appointment. Our appointment slots run in 15 minute intervals, typically on the hour. If you run late it will affect your optimum massage time and you may not get the full therapeutic effect. If you run over 30 minutes late for your appointment, it will be canceled and rescheduled for which you may incur a cancellation/late fee.

3. Please be responsible for your scheduled appointment times. The office sends out text remainders as well as a confirmation phone call as a courtesy to our patients but there are occasions when the system may not be working properly or technical difficulties may arise. It is the patient responsibility to be aware of their scheduled appointments.

4. If you cancel the same day or do not show for your appointment, you may incur a $75 cancellation/no show fee. Our therapists come in only for scheduled appointments and do not get paid if you do not show or cancel late.

We at Mulholland Chiropractic Clinic appreciate your understanding of our office policy. If you have any questions please ask our helpful front desk staff.

Patient Signature:_____

Mulholland Chiropractic Center, LLC

Independence Park Professional Center
2020 Abbott Rd., Suite 2
Anchorage, Alaska 99507
Phone: (907) 770-5700 Fax: (907) 770-5701

Activities of Daily Living and Disability Questionnaire

Name _____ DOB _____

Patient Number _____ Date _____

In order to assess your condition or gauge how effective your care has been, we need to understand how your condition affects your everyday activities. **Please answer each question and circle the level of severity** that most accurately reflects how this condition is affecting that activity.

1. Pain Intensity	(none at all)	0	1	2	3	4	5	(excruciating)
2. Frequency of Pain	(none)	0	1	2	3	4	5	(constant)
3. Use the toilet	(fully able)	0	1	2	3	4	5	(not at all)
4. Feed yourself	(fully able)	0	1	2	3	4	5	(not at all)
5. Dress yourself	(fully able)	0	1	2	3	4	5	(not at all)
6. Bathe yourself	(fully able)	0	1	2	3	4	5	(not at all)
7. Groom yourself	(fully able)	0	1	2	3	4	5	(not at all)
8. Get out of bed	(fully able)	0	1	2	3	4	5	(not at all)
9. Get out of a chair	(fully able)	0	1	2	3	4	5	(not at all)
10. Walk without help	(fully able)	0	1	2	3	4	5	(not at all)

If not on this list, what is the most difficult thing for you to do because of your condition?

_____

How severely is this condition affecting your ability to do that activity?

(fully able) **0 1 2 3 4 5** (not at all)

Score _____ Perceived Change (if applicable): _____ % Better / Worse

Patient Signature _____

Level of Disability: 0-10 minimal, 10-20, moderate, 21-30 severe, 31-50 very severe

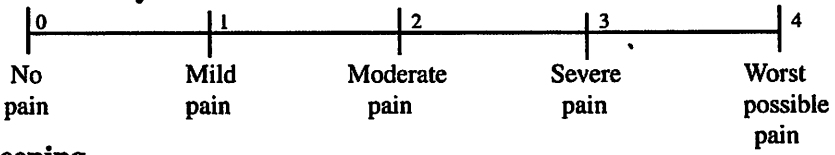
Dr. Signature _____

Functional Rating Index

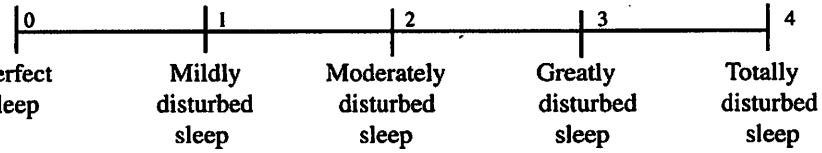
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

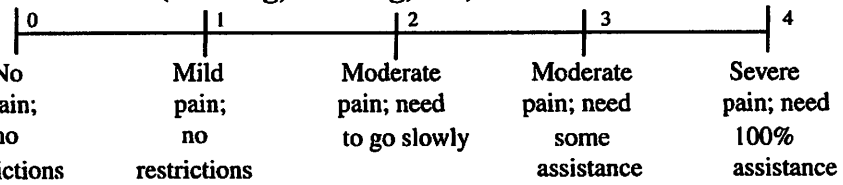
1. Pain Intensity



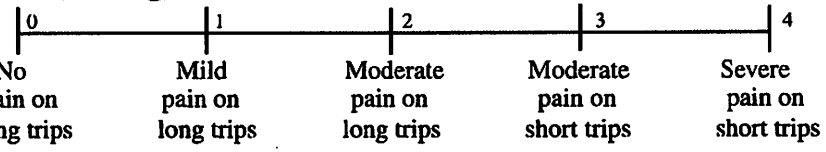
2. Sleeping



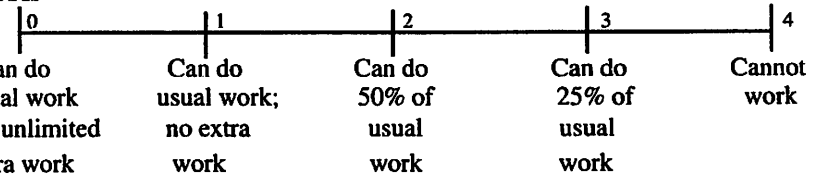
3. Personal Care (washing, dressing, etc.)



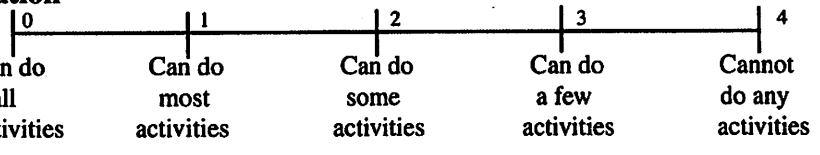
4. Travel (driving, etc.)



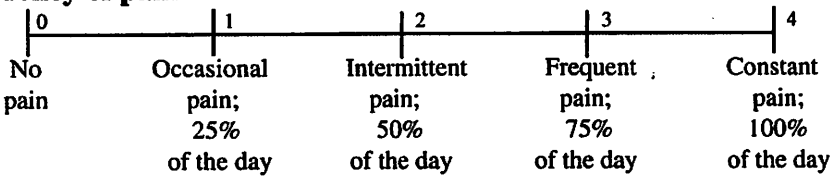
5. Work



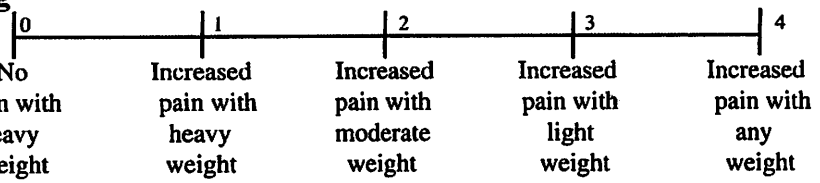
6. Recreation



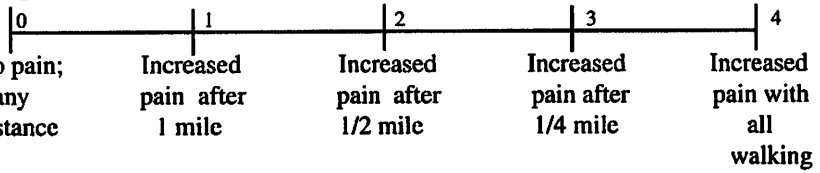
7. Frequency of pain



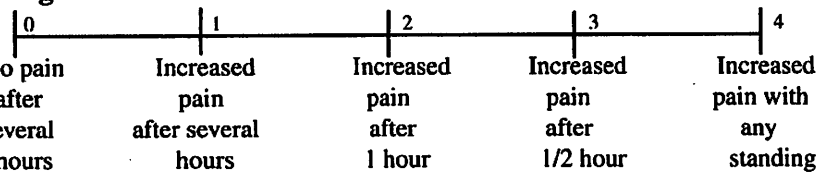
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____/40

PRINTED

_____

Signature

_____

Date