Welcome to Rizzo Chiropractic Holistic Health and Wellness Center

Check the following services you are interested in:

____Chiropractic

____ Physical Rehabilitation

____ Nutritional Analysis (Hair, Blood & Urine)

____ Detox (Sauna, Footbath, Nutritional 21 Day Detox)

____ Biofeedback (Spectra Vision/ Zyto)

____ Personal Training

Name _____MI_____

Address _____

City, State, Zip _____

Emergency Contact_____Phone _____

Home Phone _____Work # _____

Cell Phone _____ Carrier _____

Marital status-circle one [S M W D]

Spouse's name _____ No. of Children _____

E-mail address :_____
(If you want to receive monthly E-Health Tips and specials)

Birth date _____ Age _____

Height _____'_____ Weight _____Sex_____

Social Security # _____

Referred by? _____ YB [ ],

Verizon [ ], Web Site [ ] , Physician [ ], Other _____

Occupation _____

Employer's Name _____

Employer's Address _____

Medical Doctor _____

Have you had Chiropractic Care Before? _____When? _____Where?_____

What is your current complaint (be specific)? _____

How long have you had today's problem? _____ Date Symptom's Appeared _____

Have you seen other doctors or had any tests taken for this condition? _____

Is this condition due to:
☐ Auto Accident ☐ Work Injury
☐ Unknown cause ☐ Illness
☐ Other accident_____
_____

If Accident, Explain:
_____
_____
_____
_____
_____

Are Symptoms:
☐ Improving
☐ About the same
☐ Getting worse
☐ Getting worse

Have you had these symptoms before?
☐ NO ☐ YES
When? _____
Doctor's seen:
_____
_____
_____

Type of Insurance: Circle one:
MCA Administrators Medicare
Security Blue Cash Highmark
UPMC BC/BS Auto Policy
Worker's Comp
Other: _____
Group # _____
Policy # _____

Check any activities which aggravate your condition:
☐ Standing ☐ Lying
☐ Twisting ☐ Walking
☐ Bending ☐ Coughing
☐ Sitting ☐ Lifting

List Surgeries, Hospitalizations, you have had and dates.
(i.e. tonsils, appendix, etc.
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____

List all previous accidents: (auto, accidents, falls, broken bones and work injuries) When and Where?
_____
_____
_____
_____
_____

List Illnesses/conditions currently being treated for and Dr's name
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List all Prescription drugs you now take:

_____
_____
_____
_____
_____
_____
_____

List all Supplements/ Herbs and over the counter drug(s) you now take:

_____
_____
_____
_____
_____
_____
_____

Do you?

Soc. Habits

[ ]Smoke [ ]Alcohol [ ]Coffee

Stress Levels

[ ] None/Slight [ ] Mild

[ ] Moderate [ ] Severe

Exercise Activity

[ ] None [ ] Light

[ ] Moderate [ ] Strenuous

Do you use Recreational Drugs?

How often? _____

Do you have a family history of…?

- arthritis
- diabetes
- cancer
- scoliosis
- cardiovascular disease
- Other

_____
_____
_____

List allergies:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Occupational Activity [ ] Sitting 50 % or more [ ] Light Labor [ ] Manual Labor [ ] Heavy Labor [ ] Repeated Motion

Please check any of the following you may have had:

[ ] High Blood Pressure [ ] Asthma [ ] Gastric Ulcers [ ] Joint Pains [ ] Heart Disease [ ] Bronchitis [ ] Scoliosis
[ ] Colitis/Spastic Colon [ ] Jaw Pain [ ] Heart Murmurs [ ] Acid Reflux [ ] Shoulder Pain [ ] Diabetes [ ] Abdominal Pain
[ ] Pulmonary Disease [ ] Emphysema [ ] Hiatal Hernia [ ] Numbness [ ] Headaches [**M**]or [**T**] [ ] Pneumonia [ ] Multiple Sclerosis
[ ] Hepatitis A B C [ ] HIV+/AIDS [ ] Premenstrual Pains [ ] Sinus/ Allergies [ ] Gas/ Bloating [ ] Kidney Stones [ ] Tinnitus-Dizzines

The above information is true and accurate to the best of my knowledge.

Would you like us to send a report to your Family doctor? [ ] Yes [ ] No

Signature _____ Date _____

FINANCIAL POLICY

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE "Cash-Time of Service Discount" Our office call (adjustment only), for established cash paying patients is $35.00. This cash discount is only applicable **if paid at the time of service**. This discount reflects reduced administrative billing costs involved in processing cash payments compared to insurance payments. In order to get this discount, the patient must pay 100% of the charge at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established and must be in writing. However, this discount is not available on first visits or re-exams due to its more comprehensive nature.

GROUP OR INDIVIDUAL INSURANCE When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment for any noncovered services, deductibles, coinsurances or co-pays is payable at the time of service by you.

"ON THE JOB" INJURY (Worker's Compensation) If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance company and get a Claim #. You must immediately pay for any and all accumulated costs and fees associated with your care at Rizzo Chiropractic Holistic Health and Wellness Center should your employer not provide this information, or if a settlement has not been made within three months, or if you suspend or terminate care, unless other arrangements are made with Dr. Rizzo.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. You are ultimately responsible for your bill. Payment of any and all costs and fees of any and all services is due immediately upon settlement by an attorney or if you suspend or terminate care.

MEDICARE We do accept assignments from Medicare. Medicare pays our office directly. **Medicare will cover ONLY spinal manipulation for chiropractors**. Medicare pays 80% of the allowable fee

once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. If you have a secondary insurance, it may cover the remaining 20%. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

INSURANCE ONE TIME AUTHORIZATION I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Rizzo and my insurance company. I request that Rizzo Chiropractic Holistic Health and Wellness Center prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr.John M Rizzo, D.C., that fees will be due and payable immediately.

MISSED APPOINTMENTS Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. We reserve the right, at our discretion, to charge for missed appointments at the rate of $20/ office visit. Please keep scheduled appointments, and/or by calling 24 hours in advance so another patient may be fit in.

ASSIGNMENT OF BENEFITS In consideration of your undertaking to treat me, I, _____, hereby agree to the following:

1. Release of Information I authorize Dr. John M. Rizzo, D.C., to release any information he deems appropriate concerning my physical condition to my insurance company, Medicare, Pre-paid health plan, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by Dr. John M. Rizzo, D.C., or any of your staff acting on your behalf.

2. Payment Agreement I understand that there is no guarantee that my insurance company(s), pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for ***all remaining charges***. **All payments are due within 30 days of the monthly billing date. A service charge of 1.5% per month will be applied on any balance over 90 days**. Please be aware that some, and perhaps all, of the services provided may be non- covered services and not considered reasonable and necessary under the Medicare program and /or other insurances. If payment has not been received, the patient is in default and is responsible for collection, filing, court or attorney fees incurred in attempting to collect this amount now or on any future outstanding account balances. I authorize that any insurance benefits or reimbursement for services rendered you which amounts would otherwise be payable to me under any insurance plan, pre-paid health care plan, or Medicare be made payable directly to: Rizzo Chiropractic/ Dr. John M Rizzo, D.C. I also authorize the direct payment to you by my attorney out of the proceeds of any settlement of any claim based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, it is my understanding that I am responsible for your charges in full, and payment for services rendered will be made on a current basis and my account paid in full immediately.

4. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Signature of Patient: _____ Date: _____
Signature of Patient

Signature of Guardian: _____ Date: _____
(If Minor) Signature of Guardian

Rizzo Chiropractic Holistic Health and Wellness Center, Dr. John M Rizzo, D.C., ACRB3, CCN

CHIROPRACTIC SPINAL MANIPULATION (ADJUSTING)
AND SUPPORTIVE *CHIROPRACTIC CARE*
INFORMED CONSENT

I hereby request and consent to the performance of Chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic
x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss, or will have the opportunity to discuss, with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

The Chiropractic adjustment or other clinical procedures are usually beneficial and rarely cause any problems. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some rare risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, since they very seldom occur in the practice of Chiropractic, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

X_____
Signature of Patient

Date Signed_____

To be completed by representative if necessary, e.g. if patient is a minor or unable (physically or legally incapacitated).

_____
Print Patient's Name

_____
Print Name of Pt's Representative

X_____
Signature of Pt's Representative

Date Signed _____

Rizzo Chiropractic
110 N. Center Street, Ebensburg, PA 15931
711 5th Avenue, Patton, PA 16668

John M. Rizzo, DC, CCN

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff 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 to you at home, at work, by E-mail, or by your cell phone and you are not at available; a message may be left on your answering machine, with your e-mail or with your employer. By signing this form, you are giving us authorization to contact you with these reminders and information at home, at work and by these different methods.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. 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. In addition, 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.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this information. 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.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to disclose my health information in the manner described above. I am also acknowledging that I have received a copy or this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.