MURRAY
CHIROPRACTIC CENTER

2100 Kansas Ave – Great Bend, KS 67530 - (620) 792-1386

Notice of Privacy Practices Signature Page

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Daniel L. Murray Jr., D.C. - Privacy Officer**

Address: **2100 Kansas Ave - Great Bend KS, 67530**

Telephone No.: **(620) 792-1386**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

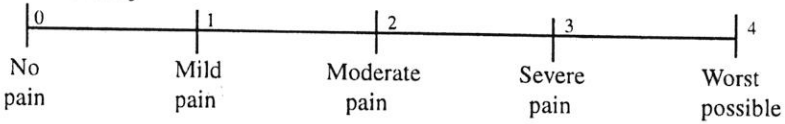
Patient: _____ Date: _____

Functional Rating Index

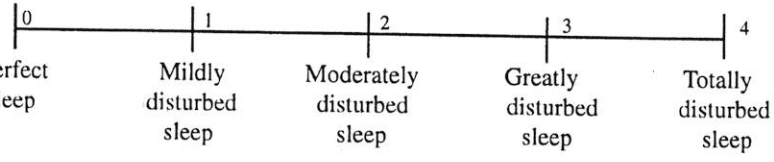
For use with **Neck and/or Back Problems** only.

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.**

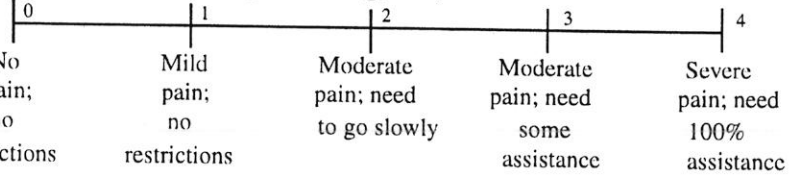
1. Pain Intensity



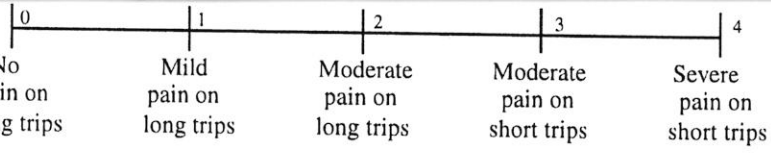
2. Sleeping



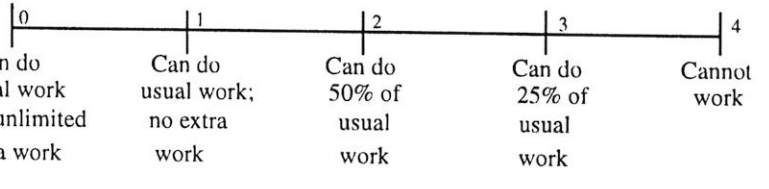
3. Personal Care (washing, dressing, etc.)



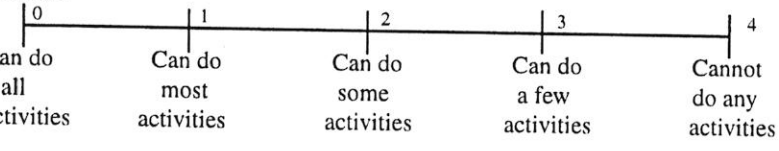
4. Travel (driving, etc.)



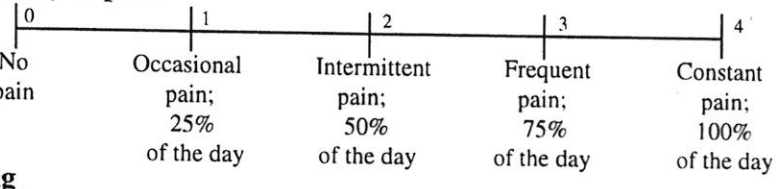
5. Work



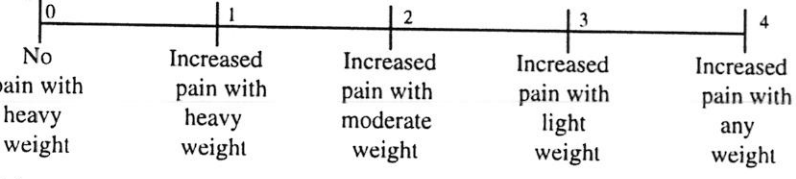
6. Recreation



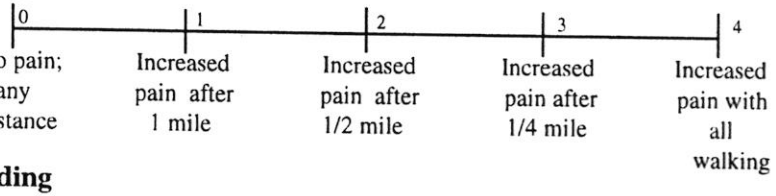
7. Frequency of pain



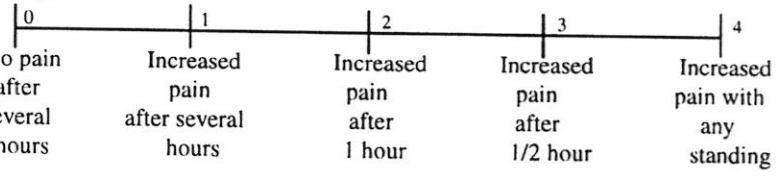
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date

"ON THE JOB" INJURY"

Worker's Compensation, in most cases, pays in full for Chiropractic care. Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's release, payment for services rendered may be due immediately. The patient is responsible for all billed amounts that Worker's Compensation does not pay.

PERSONAL INJURY OR AUTO ACCIDENT

Please present your auto insurance card and any forms as soon as possible. If an attorney is handling your case, please notify the insurance department right away. You are ultimately responsible for your bill, but our office will wait for a settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services rendered may be due immediately.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and Murray Chiropractic Center. As a courtesy to our patients, our office will complete any necessary forms at no charge, and will file them with your primary insurance carrier to help you collect. You are responsible for filing with your secondary carrier, if you have one. We will send you a completed insurance claim to send in. It is to be understood and agreed that services rendered are to be charged to you directly and that you are personally responsible for your account.

We are not certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. We expect each patient who wishes to file insurance through this office to pay the insurance deductible and the patient's percentage of co-insurance as stated in your policy. When all insurance checks have been received, we will refund any overpayment to you. You may request overages be kept on your account to be used for future visits for up to 90 days.

If you have a large deductible that has not been met, payment arrangements may be made with the office manager. Please note information below.

PATIENTS WITHOUT INSURANCE

We require that 50% of the first day visit's charges be paid at the first visit. For your convenience, payment arrangements may be made with the office manger. We are happy to accept your check, Visa, MasterCard or DiscoverCard.

An interest rate of 18% per year will be charged on all outstanding charges over 45 days. If a payment plan is needed, please speak with our Office Manager. Once your bill reaches your credit limit, you will be required to pay for all services on the day they are rendered, as well as continue to make payments on your account. We require twice-monthly payments on all accounts. Please note that no credit will be extended on nutrition, pillows or Biofreeze. These must be paid for on the same day.

Murray Chiropractic Center | Financial Policy

MEDICARE

We accept assignment from Medicare. Medicare will only cover the spinal adjustment. Once the Medicare deductible is met, Medicare will pay 80% of all approved adjustments. The patient is responsible for payment in full on all services toward deductible, for their 20% co-insurance, and for all non-covered services. Payment on non-covered services are due as services are rendered. Upon approval or denial of any adjustment by Medicare, you will be billed by statement for the portion due from you. If you have a secondary policy, please inform us. If the secondary policy is an automatic cross-over policy, Medicare will file for you. If the secondary policy is not an automatic cross-over policy, you are responsible for filing. All necessary forms will be sent to you. Your secondary checks will come to you.

THINGS YOU SHOULD DO TO HELP US FILE YOUR INSURANCE

1. Present your driver's license, insurance and /or Medicare Card to be copied and kept in your file.
2. Our office policy is that any non-covered service, co-pay, or deductible must be paid as services are rendered. After your deductible has been met, you are expected to pay for all non-covered services and for the patient's co-insurance percentage of covered services.
3. If you receive a new insurance card, become eligible for Medicare, or change insurance companies, please notify this office immediately so we can update your files and expedite your claims.
4. You are asked to authorize Murray Chiropractic Center to furnish information regarding your case to your insurance company and to assign all benefits as a result of this claim. This permits us to follow up if benefits are other than anticipated and to keep abreast of recent developments with your insurance company.

INSURANCE/PAYMENT ARRANGEMENTS

Patient Name:_____

Deductible:_____ To Be Met_____

Insurance Pays:_____% Patient Pays:_____%

Riders:_____

Payment Arrangements:_____

Responsible Party:_____

CREDIT LIMIT:_____

I agree to abide by the policies stated on this form.

Signature:_____ ***Date:***_____/_____/_____

-PLEASE NOTE THE CREDIT LIMIT. THIS DOES NOT APPLY TO NUTRITION, BIOFREEZE OR PILLOWS. THESE PRODUCTS MUST BE PAID FOR THE DAY THEY ARE RECEIVED.
-THE POLICIES SET FORTH HERE ALSO APPLY TO ANY ACCOUNTS BILLED UNDER "GREENE CHIROPRACTIC CENTER".

Murray Chiropractic Center

2100 Kansas Ave. Great Bend, Kansas 67530

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance card. All information you supply is confidential.

Today's Date | First Name | Middle Initial | Last Name | Preferred First Name | Age

Address | City | State | Zip | Birth Date (MM/DD/YY)

Home Phone | Cell Phone | Cell Phone Carrier | Social Security Number | __M __F *Gender*

Spouse's Name | Number of Children | ___Married ___Single ___Divorced ___Widowed *Marital Status*

Primary Care Provider/Office Name | *Who may we thank for your referral?/How did you find us?*

Email | Emergency Contact Name and Phone Number

If under 19 - Parent/Guardian | __Full Time __Part Time *Student* | Primary Care Provider/Office Name

Your Occupation | Your Employer and Work Address | Work Phone

Have you had chiropractic care before? | If so, from whom and when?

Please describe symptoms that you are having below. **Rate pain 0 (none) to 10 (agonizing)**

(pain, tension, muscle aches, headaches, etc.) Pain (Rate 0-10) at: WORST BEST NOW AVERAGE

Neck_____ _____ _____ _____ _____

Mid Back_____ _____ _____ _____ _____

Low Back_____ _____ _____ _____ _____

Sacroiliac Joints/Other_____ _____ _____ _____ _____

When did you first notice the symptom(s)? _____

How did the symptom(s) begin? __Work Related __Auto Accident __Injury __Other_____

How often do you feel the symptom(s)? __constant __nearly constant __50% __25% __under 25%

When do you feel the symptom(s) more? __lying down __walking __sitting __standing __bending __rising up __lifting __morning __afternoon __evening __night __other_____

Do you feel the pain radiate to other areas? Where?_____

Have you tried anything to relieve the symptom(s)? __Prescription drugs __Over the counter drugs __Surgery __Physical Therapy __Massage __ Chiropractic Care __Other_____

Does anything make the symptom(s) better? (sitting, ibuprofen, etc.)_____

Does anything aggravate the symptom(s)?(activities, movements, etc.)_____

What do the symptoms feel like? (Check all that apply.) __numb __tingling __stiff __dull __ache __sharp __cramp __burn __shooting __stabbing __throbbing __other_____

Please check any illnesses that you've *had* in the past or currently *have* below.

Musculoskeletal and Neurological Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	_____	Osteoporosis	____	_____	Arthritis	____	_____	Scoliosis	____	_____	Neck Pain
____	_____	Back Pain	____	_____	TMJ Pain	____	_____	Joint Pain	____	_____	Depression
____	_____	Anxiety	____	_____	Headache	____	_____	Dizziness	____	_____	Numbness
____	_____	Tingling	____	_____	Migraine	____	_____	Other_____			

Cardiovascular and Respiratory Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	_____	High/Low Blood Pressure	____	_____	High Cholesterol	____	_____	Poor Circulation
____	_____	Angina	____	_____	Excessive Bruising	____	_____	Racing Pulse
____	_____	Heart Attack	____	_____	Pacemaker	____	_____	Emphysema
____	_____	Pneumonia	____	_____	Asthma	____	_____	Apnea
____	_____	Seasonal Allergies	____	_____	Shortness of Breath	____	_____	Other _____

Digestive and Endocrine Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	_____	Anorexia	____	_____	Bulimia	____	_____	Ulcer	____	_____	Food Allergies
____	_____	Heartburn	____	_____	Constipation	____	_____	Diarrhea	____	_____	Hypoglycemia
____	_____	Infections	____	_____	Low Energy	____	_____	Swollen Glands			
____	_____	Hypothyroid	____	_____	Hyperthyroid	____	_____	Other _____			

Sensory and Skin Problems

HAD	HAVE	HAD	HAVE	HAD	HAVE
____	_____Blurred Vision	____	_____Ringing in Ears	____	_____Hearing Loss
____	_____Chronic Ear Infection	____	_____Loss of smell or taste	____	_____Acne
____	_____Skin Cancer	____	_____Psoriasis	____	_____Eczema
____	_____Hair Loss	____	_____Rash	____	_____Other

Genitourinary Problems

HAD	HAVE	HAD	HAVE	HAD	HAVE	HAD	HAVE
____	_____Kidney Stones	____	_____Infertility	____	_____PMS	____	_____Erectile Dys.
____	_____Bedwetting	____	_____Prostate Issues			____	_____Other

Constitutional Problems/Illnesses/Injuries

HAD	HAVE	HAD	HAVE	HAD	HAVE	HAD	HAVE
____	_____Weight Change	____	_____Low libido	____	_____Fainting	____	_____Poor appetite
____	_____Weakness	____	_____Fatigue	____	_____HIV	____	_____Alcoholism
____	_____Allergies	____	_____Cancer	____	_____Chicken Pox		
____	_____Diabetes	____	_____Eczema	____	_____COPD	____	_____Epilepsy
____	_____Glaucoma	____	_____Goiter	____	_____Gout	____	_____Heart Disease
____	_____M.S.	____	_____Malaria	____	_____Measles	____	_____Hepatitis
____	_____Rheumatic Fever	____	_____Mumps	____	_____Polio	____	_____Pneumonia
____	_____Scarlet Fever	____	_____STD	____	_____Stroke	____	_____Tuberculosis
____	_____Typhoid	____	_____Ulcer	____	_____Other_____		

____ _____Persistent cough, night sweats or fever for 2 weeks or spitting up bloody sputum

____ _____Fractures or dislocations(*please list*)_____

____ _____*Please list any other problems or illnesses*_____

Please list all medications and over the counter products, including vitamins, that you take._____

_____

_____

Please list any surgeries you have had and approximate dates.

_____

_____

Social History

Alcohol Use __daily __weekly How much?_____

Coffee Use __daily __weekly How much?_____ Prayer or meditation? __yes __no

Tobacco Use __daily __weekly How much?_____ Vaccinated? __yes __no

Soft Drinks __daily __weekly How much?_____ Mercury fillings? __yes __no

*Pain Relievers*__daily __weekly How much?_____ Recreational drugs __yes __no

Exercise __yes __no How often and what type?_____

Family History

Relative	*Age if living*	*State of health*	*Illnesses*	*Age at death*	*Cause of death*
Mother	_____	__good __fair __poor	_____	_____	_____
Father	_____	__good __fair __poor	_____	_____	_____
Sister 1	_____	__good __fair __poor	_____	_____	_____
Sister 2	_____	__good __fair __poor	_____	_____	_____
Brother1	_____	__good __fair __poor	_____	_____	_____
Brother2	_____	__good __fair __poor	_____	_____	_____
_____	_____	__good __fair __poor	_____	_____	_____

Are there any other hereditary issues you are aware of?_____

Activities of Daily Living *Please circle any activities that are affected by your pain/symptoms.*

Sitting	Grocery Shopping	Rising Up	Household Chores
Standing	Lifting Objects	Walking	Reaching Overhead
Lying Down	Bathing or Showering	Bending Over	Dressing
Falling Asleep	Staying Asleep	Computer Use	Personal Relationships
Using Stairs	Getting in/out of Car	Driving Car	Concentrating on Tasks
Exercising	Looking over Shoulder	Yard Work	Caring for Family
Working your Job	Other (please describe)_____		

What are your major stressors?_____

How do you sleep? __side __back __stomach Average sleep per night?_____hours

What are your typical eating habits? __skip breakfast __2 meals/day __3 meals/day __snacks

In addition to the reason(s) for your visit today, what additional health goals do you have?_____

_____

Acknowledgments

To set clear expectations and improve communication, please read each statement and initial your agreement.

*Initials*_____ I instruct the chiropractor to deliver care that, in his or her professional judgment, can best help me in the restoration of my health. I understand that chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. I understand that Chiropractic is a separate and distinct healing art and does not proclaim to cure any disease. I have read and understand the "*Available Treatment and Risks*" form.

*Initials*_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third party. I have read and agree to the "*Consent for Purposes of Treatment, Payment, and Health Care Operations*" form.

*Initials*_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. (Females: Date of last menstrual period_____)

*Initials*_____ I grant permission to be called to confirm or reschedule an appointment and to be sent text reminders, other texts, cards, letters, emails, or health information to me as an extension of my care in this office.

*Initials*_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I have read and agree to the "*Direct Assignment of Benefits and Authorization to Release Information*" form.

*Initials*_____ I understand that if I am a Medicare patient that Medicare only pays for adjustments of the spine and only if certain conditions have been met. I have read and understand the "Medicare Guidelines for Chiropractic" form and agree to it.

*Initials*_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern(s).

_____ _____

Signature Date (MM/DD/YYYY

_____

If the patient is a minor child, print child's full name.

_____

Staff Signature

_____

Doctor Signature

MURRAY
CHIROPRACTIC CENTER

Danny Murray, D.C.
Sclie Murray, D.C.
2100 Kansas Avenue
Great Bend, KS 67530
620-792-1386 • 800-847-3363
Fax: 620-792-8634

NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE

Your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

ALWAYS-COVERED SERVICES

A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for continued care.

MY FINANCIAL RESPONSIBILITY

I have received the above Medicare information. I understand that I am personally **financially responsible** for all services not covered by Medicare. I am also responsible for applicable annual deductibles or copayments.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.