Anderson Wellness Center
131 Buford Ave. Anderson, SC 29621

Kristen Geles-Steely DC
864-226-7676(Office) 864-226-7770(Fax)

Is this visit today due to Auto or Work Related Injuries? ONo OYes
If yes, when did this injury occur ____/____/_____

Today's Date: ____/____/_____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Nickname: _____ SS#: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Email address: _____

It's Best to reach me by - O home phone O work phone O e-mail O cell phone _____

Emergency Contact & Number_____ Primary Care Provider _____

Marital Status: O Single O Married O Divorced O Separated O Widowed Date of Birth: ____/____/_____

Spouse's Name _____ Childs Name/Age _____ Childs Name/Age _____

Childs Name/Age _____ Childs Name/Age _____ Childs Name/Age _____

Employment Status: O Full Time O Part Time O Retired O Other

Employer: _____ Length of employment: _____

Student Status: O Full Time O Part Time School _____

Who may we thank for referring you to our office
O Friend O Co-Worker O Yellow Pages O Internet O Other

Main Complaint: (1)_____

Additional Complaint (2)_____

Additional Complaint (3)_____

Additional Complaint (4)_____

Additional Complaint(s) _____

_____

Have you been to a chiropractor before? _____ **if yes, date of approximate last visit** _____

Patient ID #

Activities of Daily Living

Does your condition currently interfere With any of the following activities	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O	Grocery Shopping	O	O	O	O
Rising out of a chair	O	O	O	O	Household chores	O	O	O	O
Standing	O	O	O	O	Lifting objects	O	O	O	O
Walking	O	O	O	O	Reaching overhead	O	O	O	O
Laying down	O	O	O	O	Showering of bathing	O	O	O	O
Bending over	O	O	O	O	Dressing myself	O	O	O	O
Climbing Stairs	O	O	O	O	Love Life	O	O	O	O
Using a computer	O	O	O	O	Getting to sleep	O	O	O	O
Getting in/out of a car	O	O	O	O	Staying asleep	O	O	O	O
Driving a car	O	O	O	O	Concentrating	O	O	O	O
Looking over shoulder	O	O	O	O	Exercising	O	O	O	O
Caring for family	O	O	O	O	Yard Work	O	O	O	O

Other limited activities not listed _____

Medications

MEDICATIONS: Are you currently taking any of the listed medication?

O ADVAIR DISKUS
O ALBUTEROL
O ALEVE
O ALLEGRA
O ALPRAZOLAM
O AMBIEN
O AMITRIPTYLINE
O AMOX TR-POTASSIUM
O ATIVAN
O BENICAR
O CLAVULANA
O AMOXICILLIN
O ATENOLOL
O CELEBREX
O CEPHALEXIN
O CONCERTA
O CYMBALTA
O DARVOCET
O EFFEXOR XR
O EBMREL
O FEMHRT
O FLONASE
O FLUOXETINE HCL
O FOSAMAX
O FUROSEMIDE
O GABAPENTIN
O HRT IMIPRAMINE
O HYDROCHLOROTHIAZIDE
O IBUPROFEN
O LEVAQUIN
O LEVOTHYROXINE SODIUM
O LEVOXYL
O LEXAPRO
O LIDOCAIN
O LIPITOR
O LISINOPRIL
O LISINOPRIL-HCTZ
O LORTAB
O LOTREL
O LYRICA
O METFORMIN HCL
O METOPROLOL TARTRATE
O NAPROXEN
O NEXIUM
O NORVASC
O ORTHO EVRA
O PAMELOR
O PERCOCET
O PLAVIX
O PREDNISONE
O PREMARIN
O PREVACID
O PROPOXYPHENE NAPSYLATE
O PROTONIX
O PROZAC
O RANITIDINE HCL
O SINGULAIR
O SOMA
O SYNTHROID
O TOPROL XL
O TRIAMTERENE W/HCTZ
O ULTRAM
O WELLBUTRIN XL
O XANAX
O YASMIN 28
O ZETIA
O ZITHROMAX
O ZOCOR
O ZOLOFT
O ZYRTEC

List any other medications you are currently taking _____

Illnesses

Had	Have		Had	Have		Had	Have	
O	O	AIDS	O	O	Glaucoma	**Other Conditions**		
O	O	Anemia	O	O	Heart Disease	O	O	Artificial Bones/Joints
O	O	Anemia	O	O	Hepatitis	O	O	Chemotherapy
O	O	Alcohol / Drug Abuse	O	O	High Cholesterol	O	O	Constipation
O	O	Allergies_____	O	O	HIV	O	O	Diarrhea
O	O	Arteriosclerosis	O	O	Kidney Problems	O	O	Difficulty Breathing
O	O	Arthritis	O	O	Malaria	O	O	Fatigue
O	O	Asthma	O	O	Polio	O	O	Food Sensitivity
O	O	Blood Pressure O High O Low	O	O	Rheumatic Fever	O	O	Headaches
O	O	Cancer	O	O	Scarlet Fever	O	O	Low Back Pain
O	O	Chicken Pox	O	O	Sexual transmitted disease	O	O	Neck Pain
O	O	Congenital Heart Defect	O	O	Shingles	O	O	Sinus Problems
O	O	Depression	O	O	Stroke	O	O	Thyroid Issues
O	O	Diabetes	O	O	Tuberculosis			
O	O	Epilepsy	O	O	Ulcer			

Family History

Relative	Age (if living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	O	O	_____	_____	O	O
Father	_____	O	O	_____	_____	O	O
Sister 1	_____	O	O	_____	_____	O	O
Sister 2	_____	O	O	_____	_____	O	O
Brother 1	_____	O	O	_____	_____	O	O
Brother 2	_____	O	O	_____	_____	O	O

Personal History

Previous surgeries and dates:

_____

_____

_____

Previous Accidents/Injuries/Falls:

_____

_____

_____

Alcohol use: ODaily OWeekly How much

Tobacco use: ONever OFormer OCurrent If Yes how much _____ O Cigarettes OPack (s) per day

Coffee/Caffeine use: ONo OYes **Per Day** O <3 cups; O 3-6 cups; O >6 cups

Occupational History

Job Activities: OStanding OSitting OTyping OHeavy Lifting OWalking O Other _____

Acknowledgements

Initials: _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials: _____ I may request a copy of the Privacy Policy and understand it described how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties

Initials: _____ I realize that and X-ray exam may be hazardous to an unborn child and I certify that to my best knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):

Initials: _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails of 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 of non-covered services I receive.

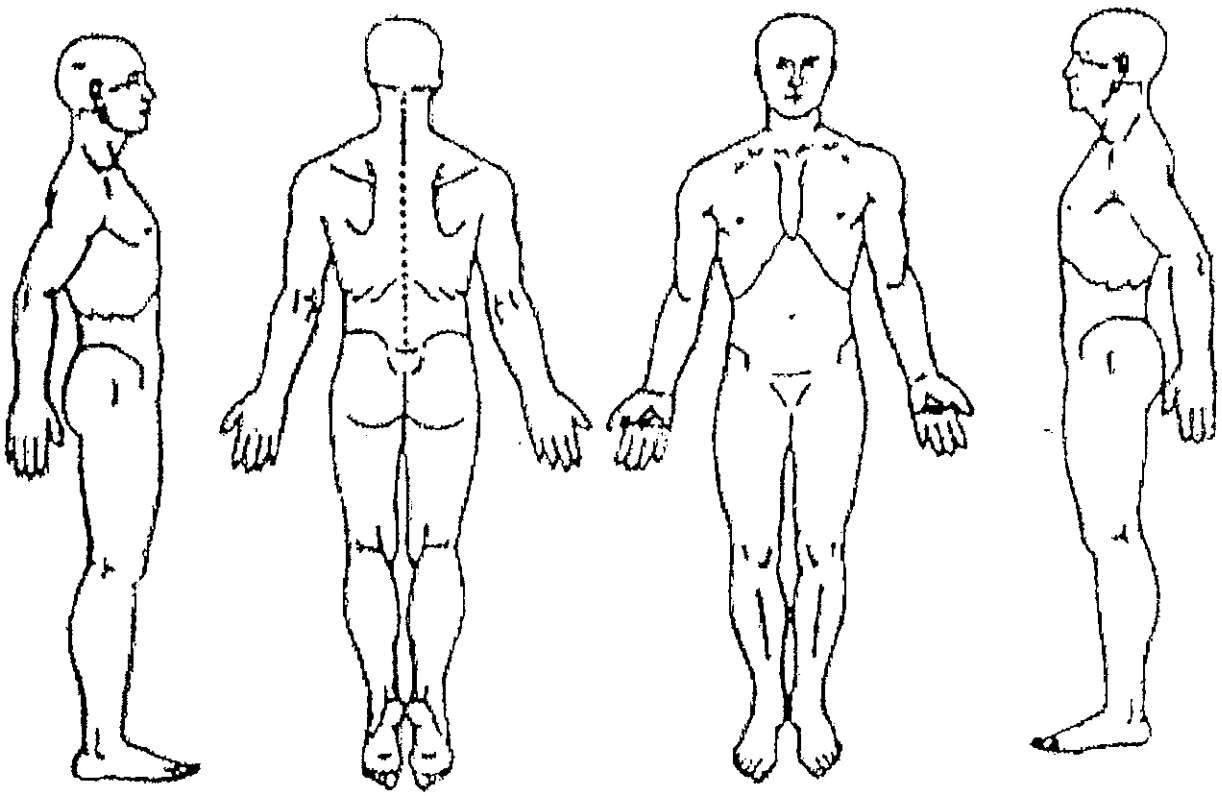
Initials: _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or my health concern.

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

_____ _____

Signature Date

Please circle area(s) of pain:



PATIENT CONSENT

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

RELEASE OF INFORMATION:
By signing the form, you are granting consent to **Anderson Wellness Center and Dr. Steely** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our HIPPA Notice of Privacy Practices provides more detail information about how we may use and disclose the protected health information. You have a legal right to review our HIPPA Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our HIPPA Notice of Privacy Practice is subject to change. If we change our HIPPA Notice, you may obtain a copy of the revised notice by telephoning our office at **864-226-7676**. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration of its intermediary carriers, any information needed for this or related Medicare or Medicaid Claims.

VERIFICATION OF NON-PREGNANCY (FEMAIL PATIENTS ONLY):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period_____.

X _____
Print Patient's Name

X_____
Patient's Signature

X_____
If other than patient, print name & relationship

X_____
Witness

Financial Policy - Updated September, 2016

Our experience has shown that it is wise to have an understanding with our patients as to our office fees and policies. Therefore, this form has been prepared for your convenience and information.

We offer several methods of payment for your care at our office and you may choose the plan that best fits your needs. This information will enable us to better serve you and help avoid any misunderstanding in the future. If special arrangements are necessary, please discuss this with the doctor during your consultation. All fees are primarily based on the usual and customary fees for our community and on the fee schedule set by the insurance commissioner of South Carolina.

Our main concern is your health and well-being, and we will do our best to help you.

CASH PLANS:

You are expected to pay in full for today's service. Fees are to be paid at the time services are rendered unless special arrangements have been made in advance. We accept cash, MasterCard, Visa, and Discover. We provide a discount for prepaid care plans. We also offer monthly payment options as well. Ask your chiropractic assistant for details.

INSURANCE:

The only insurance company we are in network with is **Blue Cross Blue Shield**. We are out of network with all other carriers. If your Blue Cross policy does not cover chiropractic benefits, you will be charged as a self pay, cash patient. You will not be granted any in network discounts.

We will file all COVERED services to your insurance carrier if you have benefits, and if you request us to do so. If a denial should process, every attempt will be made to collect payment from your insurance company based on the initial verification of benefits. In the event that payment cannot be collected from your insurance company, you are ultimately responsible for all charges that may incur.

We will file your primary insurance coverage **ONLY**; any secondary insurance will need to be filed by the policy holder. (We do not file secondary insurance policy coverage)

Since insurance reimbursement is subject to approval and cannot be accurately predicted (regardless of what insurance representatives communicate) we want to work out with you in advance how to address non-payment by the insurance company. Our experience is that insurance companies are more likely to pay if you personally pursue any denied claim(s) since you are their customer.

If your insurance company has a maximum number of visits or service maximum per year, we will not know exactly when you reach this maximum until your insurance processes. Your insurance takes approximately 2-4- weeks after your service date to process.

We will notify you of any non-payment and explain what you can do to help yourself and receive that reimbursement that is deserved.

Remember: the insurance company will often defer responsibility for their non-payment, no matter what we do or send them.

Assignment of Benefits:
I hereby instruct and direct my insurance company to pay by check made out directly to Anderson Wellness Center. If my current policy prohibits direct payment to Anderson Wellness Center, then I hereby also direct you to make out the check to Anderson Wellness Center. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved with this case. Initial _____

MEDICARE:

We are not participating with Medicare and we do NOT accept assignment from Medicare. Medicare patients are expected to pay in full for services rendered in the office and will be reimbursed at their home by Medicare.

Example: A chiropractic adjustment charge for a 98941 level adjustment is $30.00. A Medicare patient will be expected to pay $30.00 at the time the service is rendered.

SPINAL ADJUSTMENTS ARE THE ONLY SERVICE COVERED BY MEDICARE. Medicare does not cover examinations or x-rays. If you are under an ACTIVE treatment plan Medicare will usually cover your spinal adjustment. We have no control over whether or not Medicare will pay for continual treatment. Spinal adjustments for patients on maintenance or wellness care are not covered by Medicare.

To help pay for services needed, we offer monthly payment installments through Healthcare Payment Solutions to cover your cost of your total treatment programs.

Please understand that when your insurance is filed (the day you come in) it will take between 60-120 days for Medicare to process your claim and for you to be refunded by Medicare.

MEDICAID:

We are out of network with Medicaid. We do not accept Medicaid insurance.

WORK RELATED:

If you were hurt on the job and have any questions about Worker's Compensation benefits contact the Ombudsman at the South Carolina Worker's Compensation Commission. The Division of Workers' Compensation has full-time personnel who specialize in aiding injured workers with claim information and problems. They can give information about benefits an injured worker is entitled to receive. They can help try to solve problems with benefits not being paid on time, medical treatment, unpaid medical bills, questions about how to figure settlement amounts, etc. Workers' Compensation patients are expected to pay in full for services rendered in this office and will be reimbursed at their home by the appropriate parties.

Worker's Compensation Division can be reached at:

CLAIMS ADVISORY/OMBUDSMAN
DIVISION OF WORKERS COMPENSATION
P.O. BOX 1715
COLUMBIA, SC 29202-1715
803-737-5700

AUTO & PERSONAL INJURY:

These cases are cash patients unless sent from a qualified attorney. (See receptionist for attorney's we accept assignment from directly). If you do not have an attorney, you will be required to pay in full for your services at the time your services are rendered.

MASSAGE THERAPY:

We do our best to maintain a quiet and serene office atmosphere. However, we are a chiropractic office and during your massage, you may hear noises of a chiropractic clinic. There are no children or guests allowed in massage room with the client and therapist.
Massage appointments work on a rigid schedule, so if you are more than 10 minutes late for a 30 minute massage, it will be rescheduled and you will be charged a $25.00 fee. If you are more than 20 minutes late for an hour massage, you will be assessed a $50.00 fee and it will be rescheduled. We require a 2 hour advance notice to cancel a massage appointment. No shows or no notice of a 2 hour massage will be assessed a $25 fee for a 30 minute appointment and a $50 fee for a one hour appointment.

Please understand that a 60 minute massage by standard of practice is actually a 53 minute massage and a 30 minute massage by insurance standards is actually a 23 minute massage.

CANCELATION POLICY:

Reminder calls are a courtesy and should not take the place of you personally keeping up with your appointment. If you cannot keep your appointment please provide adequate notice of cancellation, (At least 2 hours before your scheduled appointment). Scheduled appointments are made to provide treatment and recovery of conditions. If you cancel your appointment, it may delay your recovery. If you must miss you need to make up the appointment as soon as possible.

For all massage therapy appointments and adjustment appointments, we have a 2 hour cancellation policy. A $25.00 fee will be incurred if we do not receive advanced notification of at least 2 hours. Insurance does not cover this fee. We appreciate a call if you are running a few minutes late.

Re-examination and new patient appointments are blocked by 30-60 minute intervals. This time is set aside for a thorough evaluation by the doctor. If these appointments are missed and not canceled within 24 hours, there will be a $50.00 missed appointment fee charged.

We look forward to serving you and helping you reach your full health potential. If you have questions on any of our policies, please don't hesitate to ask. These policies are meant to protect the general interests of all of our patients.

PAST DUE ACCOUNT BALANCES:

In the event that a balance is owed on a service rendered, you will be mailed a statement. If no payment is made, a $5.00 late fee will be charged with the second statement. The third and final statement will be mailed and assessed a $5.00 late fee. After the final statement is sent, collection activity will begin. If payment is not paid within 90 days, a 30% collection fee will be added to your bill and your bill will be sent to collections. If your bill is sent to small claims court, you will also be charged a 30% collection fee on your balance and are responsible for the court filing fee ($80).

If your bill is not paid within the 90 days in full and you require a payment plan, it will only be accepted if it is set up through HCPS (auto-draft). Balances requiring a payment plan will be charged an in house interest of 5% interest on the balance every month the balance remains unpaid.

RETURN CHECK FEE:

Returned check is assessed a $25.00 fee and no further checks can be accepted.

DISTRIBUTION AND SOLICITATION:

We ask that you avoid solicitation for the benefit of your schools, projects and fundraisers. We want to help everyone but it is difficult to help one and not to help all. And we really appreciate your understanding of this policy.

HEALTH CARE AUTHORIZATION

I _____ _____, (patient name) acknowledge that I have received, understand, and agree to the Notice of Privacy Practices of Anderson Wellness Center which describe the Practice's policies and procedures regarding the use and disclosure of my Protected Health Information created, received, and maintained by the Practice.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts the patient for such care, it is essential that both are seeking and working for the same goal – to locate, analyze, and correct vertebral subluxation, which cause interference to the nervous system. It is important that each patient understand both the objective and the method that will be used to obtain it to avoid confusion or misunderstanding.

We do not diagnose conditions of disease other than that which relates to vertebral subluxation (spinal misalignments). However, if during this course of chiropractic spinal exam, we encounter conditions that warrant medical attention, we will recommend that you seek the services of a provider who specializes in that area. We offer no treatment of conditions other than that which relate to vertebral subluxation. Our primary role is to identify subluxation and our primary method of correcting them is through spinal manipulation (adjustments). In doing so, this office uses an open adjusting area with semi-privacy walls. We assure you that all of your personal information will be kept confidential and the appropriate discretion will be used. If this is a problem, please inform one of our staff members or the doctor.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service (excluding Workman's Compensation). It is also understood and agreed the amount paid to the office for x-rays is for examination only and x-ray films will remain the legal property of the office. I hereby authorize the doctor to examine and render treatment.

By signing below, I verify that I have read and agree with the terms and conditions of Anderson Wellness Center's Financial Policies, Health Care Authorization, Treatment, and Terms of Acceptance.

Print Patient Name_____ _____Date_____ _____

Patient Signature_____ or _____Date_____ Guardian _____

Anderson Wellness Center

1704 East Greenville St.
Suite C
Anderson, S.C. 29621
Tel. (864) 226-7676

Kristen M. Geles, D.C.
Chiropractic Physician

Most of the patients that visit our office are on an affordable cash wellness plan. If you plan on using your health insurance, please provide the following information necessary for us to bill your insurance carrier.

Who is responsible for this account? _____
Relationship to patient? _____
Insurance Company _____
Policy ID # _____
Group # _____
Subscriber's Name _____
Birthday of Subscriber _____
Social security # of subscriber _____
Social security # of patient _____
Subscriber's employer _____

Assignment and release:

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Geles 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 authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above – named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient's signature _____

Guarantor's signature _____

Patient Policies

1. Patient must sign in at every visit.

2. Indicate on the SOAP note how you are feeling today and let us know of any new problems you have. *Don't forget name, date, and date of birth.* Do not leave anything blank.

3. Lie face down on the adjustment table. The reason we request that you do this is to relax; when you are relaxed, you receive a better adjustment.

4. REMINDER: If the doctor comes in to the adjustment room and the SOAP note is not filled out completely or you are not lying face down, the doctor will have you do this while moving on to the next patient.

5. To hold your preferred appointment time, we request all appointments be prescheduled.

6. All new injuries & concerns, re-exams, and consultations are to be discussed during extended hours not at your preferred appointment time.
   - Preferred hours *(adjustment only)*: 8:30-10:30; 3:30-5:30
   - Extended hours *(new problems, re-exams, consultations, new patients)*: 10:30-12; 2:30-3:30

7. Your results are obtained based on the number of visits per week, not per month. Therefore, it is vital to hold to your treatment plan schedule. If an emergency arises and you are unable to make your appointment, we ask you to notify us as soon as possible. An official make up appointment will be assigned for the following day at the same time. If you are prescheduled and miss three appointments in a row, you will be charged a missed appointment fee and all future appointments will be removed.

8. Payment is expected on the date of service unless you have an arranged payment plan with Healthcare Patient Solutions. If insurance does not pay after your visit has been filed, you have 30 days to pursue the claim *with your insurance company.* You will need to contact them.

Sign & Date _____