River Ridge Chiropractic and Natural Medicine

Patient Intake Form - MVA

Name_____

Date of Birth_____ Ht_____ Wt_____

Street/PO_____City_____St_____Zip_____

Cell Phone_____ Home Phone _____ Work Phone_____

TEXT Appointment Reminder - **YES** _____ **NO** _____ Cell Carrier _____

Home Email_____

Employer's Name_____ Position _____

Employer's Address _____

Emergency Contact_____ Phone_____

Relationship _____ Referred by_____

Reason for visit: _____

Date of accident? _____ Have you been treated for this condition? _____

If **yes**, please describe _____

Date of last physical_____ Name of current Physician_____

Are you taking any medications? _____ If yes, please list _____

Person responsible for payment (if other than patient)_____

Insurance Company_____

*Policy Holder's Name_____*DOB_____

*Policy Holder's Address _____

*Relationship to Policy Holder_____ Policy Holder's Employer_____

Insurance Information

I understand and agree that health insurance policies are an agreement between an insurance carrier and myself. Furthermore, I clearly understand that this chiropractic office will prepare my necessary reports, and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Consent of Professional Services and Release of Information

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case, and I further authorize him to disclose all or any part of the clinic's record to any person or corporation which is liable under a contract to the clinic or to the patient for all or part of the clinic's charge including but not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare compensation carriers or the patient's employer.

Patient (or) Guardian Signature_____

Today's Date_____

*We MUST have subscriber's/policy holder's information to file your insurance. Thank you!

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT? ❑ Yes ❑ No

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor Appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Exercise
- ❑ Drug Abuse
- ❑ _____

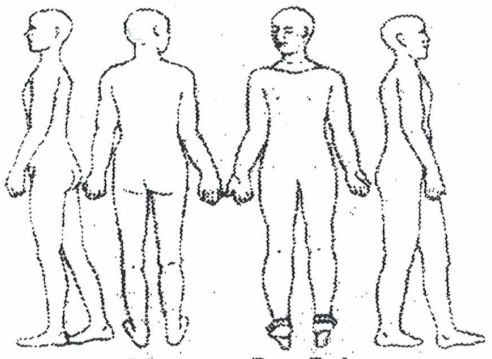
CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE .....

_____

_____

_____

_____

Patient accepted? ❑ Yes ❑ No Doctor's Signature _____

Form-09/B

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score ☐

River Ridge Chiropractic and Acupuncture
1201 Bleachery Blvd, Ste 203
Asheville, NC 28803

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 RIGHTS

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example:*

A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective

YOUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

services.**espond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

This notice is effective as of _____. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Print Name _____

Signature _____ Date _____

If you are a minor being represented by another party:

Print Name of representative _____

Signature of representative _____

River Ridge Chiropractic and Natural Medicine
Dr. Bart Hodgins, DC., Dipl. Ac.
1201 Bleachery Blvd, Ste 203
Asheville, NC 28803
(828) 274-6602

Automobile Accident Questionnaire

Please answer all questions completely

Date_____

Patient Name _____

Street Address_____City_____State_____Zip_____

Date of Accident _____/_____/_____ Time _____ **AM / PM**

Their Insurance Company:

Have you been contacted by anyone from **Their** insurance company? YES_____NO_____

Company Name_____

Mailing address_____

Phone #_____

FAX#_____

Policy #_____

CLAIM #_____

Adjustor's Name_____

Driver of the **Other** Vehicle_____

Your Insurance Company:

Have you been contacted by anyone from **Your** insurance company? YES_____NO_____

If so, by whom:_____

Company Name_____

Mailing Address_____

Phone #_____

FAX#_____

Policy #_____

CLAIM #_____

Who was the **driver** of the vehicle you were injured in?_____

Have you retained an attorney? YES_____NO_____Not yet but I intend to _____

If so, Atty. Name_____

Mailing Address _____

Phone # _____

Were the police notified? YES_____NO_____

Did your head strike the windshield or other object? YES_____NO_____

Were you knocked unconscious? YES_____NO_____ If so, for how long?_____

You were struck from/on? Behind_____Front_____Left side_____Right side_____

You were? Driver_____Passenger_____Front seat_____Back seat_____

Using seat belt_____Other protective devices_____

Did you feel pain immediately after the accident?
YES_____NO_____Where?_____

Where were you taken after the
accident?_____

What treatment was
given?_____

Was any Doctor consulted after the accident?YES_____NO_____If so, name
_____

Doctor's diagnosis?_____Treatment
given?_____

_____
_

Have you ever had complaints in the involved area before? YES_____NO_____

Before the Accident, were you capable of doing normal daily activities? YES_____NO_____

Are your working activities restricted as a result of this accident? YES_____NO_____
How?_____

Since the accident, are your symptoms: Improving?_____ Getting Worse?_____ The Same?_____

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AUTO ACCIDENT INSURANCE BILLING

Insurance Options:

The different insurance options available to you can be confusing.

Most people use their medpay, as well as billing the at-fault party. Medpay is like a personal insurance coverage for medical bills that many people have as part of their auto insurance policy. When you use your medpay to cover medical expenses, it does not affect the cost of your auto insurance. Since there is never a guarantee that the at-fault party's insurance will pay all medical bills, and since you are responsible for any charges for which the at-fault party's insurance does not pay, it is for your protection to use your medpay to cover medical expenses as you go. The important thing is to get the healthcare you need, when you need it.

Medpay payments go toward satisfying the Lien. If you receive a medpay payment, it is important to bring it to us even if you think the at-fault party's insurance will pay all the bills. It cannot look motivating for you to be coming to the doctor's office. Insurance companies consider profit driven visits to be fraud, and they may try to deny the entire claim. When your treatment is complete, the at-fault party's insurance is only required to pay us the balance due *after* medpay in order to satisfy the Lien. If the at-fault party's insurance pays us for charges already paid by medpay, we will then write you a check for the positive balance. At-fault insurance companies are, by North Carolina law, required to pay the full amount of your medical bills.

You do not have to use your regular health insurance if you do not want to.

Things to Know About Your Regular Health Insurance:

If you choose not to use your regular health insurance, they will not receive any information pertaining to your accident related care, leaving your insurance funds available should you need them.

If you choose to use your regular health insurance, you are required to pay all applicable co-pays and deductible amounts at the time of service. Also some health insurance companies have what is called subrogation. This means that in the case of an auto accident, if there is a settlement, you are required to pay the insurance company back out of the settlement money.

Your Choice:

If you choose to use your regular health insurance, they will be billed at the allowable rates. We need to know now whether you do want to use your regular health insurance, as we do not bill retroactively. You do not have to use your regular health insurance.

_____**Yes**, I wish to use my regular health insurance. I understand that my medical information may be sent to them, subrogation may apply, and I have to pay all deductible and copay amounts at time of service.

_____**No**, I do not wish to use my regular health insurance.

Signature_____ Date_____

If you have any questions, please ask us.

River Ridge Chiropractic and Natural Medicine
1201 Bleachery Blvd, Ste 203
Asheville, NC 28803
828-274-6602

MEDICAL RECORDS RELEASE FORM

RE: PATIENT: _____

Last 4 SS#: _____

DOB: _____

This is to authorize Dr. Bart Hodgins, DC to release any and all medical information or opinion which may be requested by another doctor regarding my physical condition and treatment rendered. This would include any x-rays or MRI reports which Dr. Hodgins may have regarding my condition or treatment.

_____

Patient Signature

_____

Date

River Ridge Chiropractic & Natural Medicine
1201 Bleachery Blvd, Ste 203
Asheville, NC 28803
828-274-6602

PATIENT AUTHORIZATION
For Appointment Reminders and Scheduling Related Matters

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, or other appointment related issues. The use of this information is intended to make your experience with our office more efficient and productive.

If you choose not to authorize the use of this information by our staff, your decision will have no adverse effect on your care from River Ridge Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name: _____

Signature: _____

Date: _____

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Patient Guide to River Ridge Chiropractic & Natural Medicine

1201 Bleachery Blvd, Ste 203
Asheville, NC. 28803

Thank you for choosing River Ridge Chiropractic & Natural Medicine to be your healthcare provider. We appreciate having the opportunity to be a part of your optimal health. The following summary of our financial policies is designed to answer questions and concerns you may have about our financial relationship. Please let us know if you have questions that aren't addressed in this notice.

Patient Appointment Hours:

Mon, Wed, Thurs: 7:45 am – 11:45 pm & 1:45 pm – 4:45 pm
Tues: 7:45 pm – 11 am
Closed Daily 12-1:30 for Lunch
If you are unable to keep your scheduled appointment, we request 24 hours notice, so that we may have that time available for another patient who may be needing treatment.

Contact Information:

Telephone: 828-274-6602
Fax: 828-274-6604
Email: riverridgechiropractic@gmail.com
Website: www.riverridgechiropractic.com

Payment Methods

All payment is expected at the time of service. We accept cash, personal checks, debit cards, Visa, Master Card, Discover, and American Express. There will be a $15 service fee for returned checks.

Insurance

We are in-network providers for most major health plans, and are happy to file claims on your behalf. In order for us to file your insurance claims, we will need to have all necessary information, including a copy of your current valid insurance card. Under the terms of our contract with the various health plans, payment of copays, deductibles, and/or co-insurance is due at each visit. As the patient or guardian, we recommend that you be familiar with the contract between you and your insurance carrier, and fully understand the benefits of your policy. We make every effort to obtain accurate information from each insurance company, however, we cannot guarantee that services or products will be covered until the claim has been processed and reimbursement made by the insurance company. Services not paid by an insurance company are the responsibility of the patient or account guarantor.

Auto Accidents/MVA's

We file liability and med-pay insurance claims for auto accidents claims. To expedite the filing and payment of your claims, we request a copy of the police report (if applicable), insurance information including claim numbers, mailing addresses, and phone numbers for all parties involved. Denied or unpaid personal injury claims are the responsibility of the patient.

Billing
If there is a balance on your account we will do our best to send you a timely billing statement, however it is your responsibility to make sure your account is paid in a timely manner. For accounts sent to an outside collections agency, there will be a 30% finance charge added to the balance due.

I have read and understand the terms of the above agreement.

Name: _____

Signature: _____

Date: _____

Assignment of Benefits

I hereby assign to Dr. Bart Hodgins and River Ridge Chiropractic all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment checks directly to River Ridge Chiropractic for all medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Print Patient Name:

_____

Patient/Responsible Party
Signature:

_____

Date: _____