Tyran G. Mincey D.C

27 Downing Street
NY NY 10014
(212) 463-7315

295 Bloomfield Ave.
Montclair NJ 07024
(973) 744-1155

Your first visit.

1. Please fill out the office forms enclosed.

2. Dr. Mincey or another authorized person will review your history.

3. You will be examined by Dr. Mincey

4. Any necessary tests will be ordered or performed.

5. After examination and testing the visit will end and another visit will be scheduled.

6. This process may take anywhere from as long as one hour.

7. During this second visit Dr. Mincey will review all of the findings from testing and examination. At this time we will determine whether we will accept your case. If so then treatment options will be presented to you as well as the estimated cost and time frame of treatment. You will be given an opportunity to get all of your questions answered at this time.

8. Extended treatment will not be given on the first visit.

Expectations

We understand that you have the expectation to get well and that is the goal of this care. As with all types of health care and medical care there are no guarantees made in any way shape or form except that we will do everything possible to help your body heal itself and when we have done all we can we will let you know and advise you of other options. Our success rate of helping people in this office is about 90-95%. With regard to how long it will take to heal, in some cases healing seems almost instant while in others it is more gradual. There are many variables that impact healing time these include your compliance with Dr.'s recommendations, overall lifestyle, diet and other factors that may be unique to you. (Please remove all jewelry and turn off cell phones before entering examination room.)

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Integrated Health Care
Tyran G. Mincey D.C.
295 Bloomfield Avenue Ste. #5
Montclair NJ 07042
(973)744-1155

27 Downing Street
NY NY 10014

(212) 463-7315

Financial Policies

1. Payment is due at the time that services are rendered unless other terms have been arranged.
2. A payment plan may be available to assist you in getting the care you need. If the payment plan is broken then the full amount will be due.
3. We accept payment in the following forms, cash, check (postdated is acceptable), credit cards (Visa, MasterCard)
4. Bounced check fee is $50.00 per occurrence. If a check bounces 2 times we will no longer accept checks and all visits will have to be paid by cash or credit card
5. All supplements, accessories, foods, toiletries, oils, and any other items purchased must be paid for at the time of sale. No exceptions will be made.
6. If we accept your insurance the copayment will not be waived and is due after services are rendered. We also request that you sign the attached document and provide us with your Visa/MasterCard information in the event that the insurer refuses payment. You will be notified prior to any charges going on your card.
7. Our Fee structure on a per visit basis follows;

For cash payers

First visit: ***Initial Exam*** cost $210.00

Duration is dependent on patient's presentation.

Description

1. **Taking of a detailed history**
2. A Comprehensive physical examination (blood pressure etc), complaint oriented examination. Chiropractic examination of spine, muscles and nervous system and entire body.
3. Applied kinesiology examination which includes meridian examination,
4. Minor diagnostic testing such as Spirometry, Ph of saliva, Zinc deficiency, Homocysteine screening, nerve balance screening, aerobic deficiency screening, electrolyte imbalances, emotional screening, Body fat testing. Other examinations may be needed depending on individual need.
5. Any other Lab tests and X-rays will be extra if needed.

Second visit minimum Cost $75.00

Description: Review of findings: presentation of case, with a treatment plan, outline of the time, expectations, and whether or not we will accept your case, referrals are made if need be.

Third visit and any thereafter minimum Cost $75.00

Description: Our goal each and every visit is to balance the nervous system. We do this using a variety of therapies and do not charge cash payers by therapy type. This may include

suggestions for supplementation, lifestyle changes, exercises, total hands on muscle, and joint adjusting, accupressure, reflexology, use of essential oils etc.
Extended visits are available; ask Dr. Mincey.

For patients who have insurance everything above applies except that the insurers may not pay for certain therapies and we must bill what is reasonable and customary by therapy. So you may be required to pay a portion of the care that your insurer will not underwrite. Dr. Mincey will advise you as such prior to beginning any treatment. A portion of the initial examination may not be paid for.

I _____ have read and understand and agree to abide by the terms as outlined and applying to the office of Integrated Health care, LLC. I understand that if my insurer will not cover costs of services that I am responsible and agree to pay them.

Signature:_____
Date:_____

Print name _____ Date _____

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Pediatric form

Patient Name:_____

Address:_____ City/State/Zip: _____

Phone:_____ Social Security # _____ ___ _____

- Parent/ guardian name:_____
- Email address: _____

Parent Phone at work:_____

DOB: __/__/___ Age: _____ Weight _____

Sex M F No. Of siblings: _____ Native language: _____

Handedness right left ambidxt. Race:_____

No. of hours of sleep per night: _____ Quality of sleep: good Fair Poor

---

Present MD and address: _____

Date of last MD visit:___/___/___

Previous D.C. and address: _____

Authorization for care of a minor

I hereby authorize Tyran G, Mincey D.C. and whomever they may designate to administer care as they deem necessary to my son/daughter.

Signed:_____
Witnessed:_____
Dated this _____ day of _____ 20__.

Chief complaint

How did you hear about this office ?

_____

Reason for contacting us ?

_____

Date of onset (when did the problem start) ?

_____

Onset was: sudden Gradual

Duration of pain/problem/episode:_____

Pattern of pain/problem: _____

Initiating factors: _____

Exacerbating factors: _____

Diminishing factors: _____

How does problem effect child's daily body function and activities ?

_____

_____

_____

Prenatal History

Duration Gestation:_____ weeks

Pregnancy normal: Yes No

Did you have unusually high energy levels during the pregnancy at any time? Yes No

Did you "crash" after the pregnancy? Yes No

Did you suffer from any postpartum symptoms? Yes No

Did you supplement during the pregnancy? Yes No If yes with

what?_____

List any complications or injuries during pregnancy:

_____

_____

_____

_____

Was they delivery normal Yes No

Were drugs used for delivery ? Yes No

List any complications of delivery:

_____

_____

_____

List any medications taken during delivery:

_____

_____

_____

Forceps used for delivery ? Yes No
Place of Birth: Hospital Home Birthing Center

About the birth
Apgar score: _____
Apgar score at 5 min. _____
Weight at birth: _____
Length at birth: _____

Developmental history

Was infant alert and responsive within twelve hours of delivery? Yes No
If "No", explain:

_____
_____
_____
_____

<u>At what age did child:</u>
Respond to sound: _____
Follow an object with his/her eyes:_____
Hold head up: _____
Sit alone: _____
Crawl: _____
Stand: _____
Walk alone: _____
Was child every place in a walker? :_____

Nutritional History

Breastfeed _____ Months
Cow's milk began Age _____Other milk:_____ Age Began _____ for _____ months.
Began solid food at age _____ months
Were commercially prepared baby food used ? Yes No
Type:_____
Food/ Juice Intolerance ? Yes No Type: _____

Current diet type: (Vegan) (Vegetarian) (Omnivore) (Meat Eater) (circle one)
Does child eat Raw Vegetables? Yes No
Does child eat any veggies besides French fries, corn and string beans? Yes No
Does child drink cows milk? Yes No

Is child currently taking any type of nutritional supplements?
1. _____ Why _____
2. _____ Why _____
3. _____ Why _____
4. _____ Why _____

Social Behavior

Seems normal for age: Yes No
If "No", explain
_____

_____

Childhood diseases

Y	N	Chickenpox	Age _____
Y	N	Mumps	Age _____
Y	N	Measles (Rubella)	Age _____
Y	N	Measles (Rubeola)	Age _____
Y	N	Whooping Cough	Age _____
Y	N	Other	Age _____
Y	N	Immunizations (list type and age	

_____
_____
_____

_____
_____
_____
_____

List any significant family history or injuries of any sort (e.g. cancer, diabetes, heart disease, falls, breaks, stitches, etc.):

_____
_____
_____

Females:

Menarche: Age _____ Year _____

Menstrual Flow: scant light moderate heavy

Menstrual regularity: Days in cycle: _____ Duration of menses: _____ (days)

First day of last period: _____/_____/_____

Menstrual cramping ? Yes No (degree of severity: (0 1 2 3 4)

Vaginal Discharge ? Yes No frequency_____

description _____

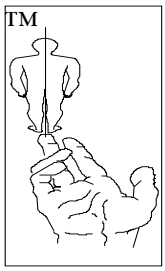
Amount_____ Odor_____ Color _____

Itching or burning in vagina or rectum ? Yes No (frequency_____)

Abnormal or painful premenstrual fluid retention ? Yes No

List any hospitalizations, injuries medications, trauma Etc.

_____
_____
_____
_____
_____
_____
_____



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Financial Policies

Accounts Receivable Policy Letter

We first want to thank you for choosing Integrated HealthCare LLC as your healthcare provider. We consider it a privilege to serve you.

With service in mind, effective **09/30/2005**, we are advising new patients, and updating existing patients, to our new payment and billing policies to avoid possible misunderstandings or difficulties at a later date.

By far the majority of our patients regularly pay their accounts within a reasonable amount of time. In order to insure the level of service you require and deserve, without added cost, we have integrated a new program to hold down our operating expenses. Our new payment policy and program ensures that **your account** will not be penalized to cover costs incurred by us from those who do not pay in a timely manner. The accounts receivable policy that we follow states that:

1. **Insurance.** If you ***are not*** insured by a plan with which we are participating, payment in full is expected at each visit. If you are insured by a plan with which we are participating, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Account balances over 30 (thirty) days are subject to interest charges of 1 ½% per month (18% per year). Unpaid accounts reaching 60 days will be automatically transferred to Transworld Systems, Inc. for the purposes of collecting on your account. An additional fee of $10.00 will be added to your accounts and is due in addition to any balance and interest charges owed.

3. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or medically necessary by your insurance company. If you still opt to receive these services, you must pay for them in full at the time of your visit unless other arrangements have been made ***prior*** to receiving them.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance.

We thank you in advance for your understanding, support and agreement in this matter.

If you have any questions regarding this policy, or would like to discuss your account at any time, please feel free to contact LaTisha or Dr. Mincey at 973-744-1155 to arrange a confidential review of your personal account.

Sincerely,

Tyran G. Mincey D.C.
Chiropractic Physician