WELCOME TO OUR PRACTICE

Patient's Name:_____	Date of Birth:_____Age:_____
What do you prefer to be called: _____	Male: _____ Female: _____
Address: _____	Home Phone: _____
_____	Cell: _____
(City) (State) (Zip)	Work: _____
SSN:_____	Email: _____
Employer: _____	Occupation: _____
Marital Status: M S W D	Spouses Name: _____
Primary Ins. Company:_____	**Secondary Ins. Company**: _____
Name of Subscriber:_____	Name of Subscriber: _____
Subscriber's SS#: _____	Subscriber's SS#: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Relationship to Patient: _____	Relationship to Patient: _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) _____ Yes _____ No

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to this chiropractic office all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

For Office Use: **File #:**

Welcome Postcard: _____ **Next Welcome Form Due: _____** **Entered in System:**

Terms of Acceptance

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Consent to Evaluate and Treat a Minor

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Women Only (circle 1 in each section)

To the best of my knowledge, I (AM / AM NOT) pregnant and I (GIVE / DO NOT GIVE) permission to x-ray me for diagnostic interpretation.

Communications

In the event we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

NONE: _____

EMERGENCY CONTACT (PHONE): _____

May we mail postcards or leave messages on any answering device, i.e home answering machines or voicemails?

Yes [ ] **No** [ ]

I, _____, have read and fully understand the above statements.

Signature: _____ Date: _

INFORMED CONSENT FOR TREATMENT

PATIENT NAME: **PATIENT FILE #:**

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I _____do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine and exercises. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is consiered to be one of the safest and most effective form of therpy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

1. **Soreness:** It is common to experience muscle soreness during treatment
2. **Uncomfortableness:** Temporary symptoms (dizziness, nausea) can occur, but are rare.
3. **Fractures/Joint Injury:** Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
4. **Stroke:** Strokes from chiropractic adjustments are rare.
5. **Burns:** Some therapies used generate heat and may, in rare cases, cause burns.

Treatment results: I understand there are benefits asociated with treatment including decreased pain, improved mobility and function, and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatments Available: Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing and provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

_____
Patient's Signature

_____
Witness Signature

_____
Date

PATIENT STATUS AT TIME OF CONSENT

- ☐ OF LEGAL AGE
- ☐ ORIENTED x3
- ☐ COHERENT/LUCID
- ☐ PROFICIENT ENGLISH
- ☐ ASSISTED BY INTERPRETER

_____

- ☐ MEDICATED, BUT UNIMPAIRED
- ☐ DENIES USE OF ALCOHOL OR RECREATIONAL DRUGS PRIOR TO CONSENT
- ☐ UNABLE TO GIVE LEGAL CONSENT
- ☐ CONSENT VIA LEGAL GUARDIAN

_____

Patient's questions (if any) and responses are as follows:

Comments:

I certify that this form accurately reflects the patient's status during the informed consent process.

_____
Doctor Signature

_____
Date

PATIENT FINANCIAL POLICY

Welcome to our practice and thank you for choosing us for your chiropractic care. We feel it is important for you, our patient, to be informed of the financial policies of this practice. We encourage you to discuss any questions or concerns you may have regarding these policies.

- Patients cannot be seen without a current insurance card. If you do not have a current insurance card at the time of the appointment, payment in full will be expected at time of service.
- If the insurance company requires a referral it is the patient's responsibility to obtain the referral from their primary care physician prior to the visit. If a referral is necessary but not obtained the appointment will need to be rescheduled or the patient may pay for the visit in full at time of service.
- We will bill your primary and secondary insurance plans for all services rendered. You will be responsible at the time of service for payment of co-payments and charges for non-covered services billed to your insurance. You will also be responsible for your deductible. We do offer a time of service discount on services that may not be covered by your insurance. If you choose to pay at time of service to receive the discount, those services will not be billed to your insurance. In the event that we are not aware of a charge that is not covered by your insurance, you will be billed for the balance after we obtain a denial from your insurance carrier. If you have insurance coverage with a carrier that we are not contracted with, you will be responsible for payment in full at time of service.
- If you have never been to our office, or if it has been three (3) years since your last visit, be advised there WILL be a new patient exam to determine treatment options.
- For your convenience we accept cash, check, Visa, MasterCard and Discover.
- Due to the additional handling and charges made to us by the bank, there will be a $30 charge for all returned checks. We will contact you and request a cash payment for the amount of the check and the added fee.
- Any account overdue by more than 60 days from insurance's final payment for the visit may be referred to a professional collection agency.
- This office charges $20 for missed appointments without 24-hour notification.
- Treatment of minors: We realize that many families are in a state of change. Divorced, separated, single parents and blended families are now common. In many of these families the question of who is financially responsible for the child's care can be complicated. The policy of this office is that the parent who requests treatment for/accompanies the minor is responsible for the fees incurred.
- Disability forms: Disability forms can be very time-consuming to research and complete. These may include forms such as AFLAC and FMLA. A charge of $10 for each form that is required to be completed will be payable at the time the form is presented for completion.

Agreement to Pay for Services

I agree that I may have to pay for the services provided to me by this chiropractic office. Even though I may have insurance coverage, I have final responsibility for payment to the practice. I therefore agree to pay for all medical charges my insurance does not cover either at the time of service or as soon as I receive notice. If I do not pay for the services within the specified time frame, I understand that I will also be responsible for all costs incurred by the practice in collecting such charges, including attorney fees, court costs and or collection expenses.

Patient signature: _____ Date: _____

Parent/Guardian Signature: _____

(Required only if patient is a minor)