Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_
Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MemberID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Policy Holder (Insured’s Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB: \_\_\_\_\_\_\_\_\_\_\_
 Relationship to the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MemberID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Policy Holder (Insured’s Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB: \_\_\_\_\_\_\_\_\_\_\_
 Relationship to the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you have an HSA or HRA? Yes No
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Informed Consent, HIPPA & Office Policies – Contract
(Please read & initial each statement, then sign below)

\_\_\_\_\_\_ I have been informed that is is not uncommon for patients to have increased discomfort after therapy. If this happens, I will apply ice to the area & rest. If I am concerned about this discomfort or develop any new symptoms, I should call the office as soon as possible. If needed, I should present myself to an emergency room or call 911. Treatment is hands on and by machine and with any procedure there are risks and side effects possible. Communication is essential, if I am uncomfortable or concerned about any procedure or have any side effects, I am to stop the procedure and tell the doctor immediately.

\_\_\_\_\_\_ I hereby request & consent to examination, chiropractic & other procedures to be determined by the doctor including various modes of physical therapy and massage. Our scope of practice and training does not include the treatment, evaluation or diagnosis of cancer, fractures, tumors, organ pathology, diabetes, vascular, or any medical pathology. I am advised to speak with my medical doctor about all conditions. I understand & am informed that, as in all healthcare, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle strains/sprains, fractures, disc injuries & strokes. I do not expect the doctor to be able to anticipate & explain all risks, alternatives & complications. I wish to rely on the doctor to exercise judgment which the doctor feels are best at the time, based upon facts then known.

\_\_\_\_\_\_ I hereby authorize you and your employees to furnish anyone designated in writing by me, all copies of records & reports, concerning any condition that I may have had in the past, now have, or may have in the future. I give permission to use my address, phone number & clinical records to contact me with appointment reminders, missed appointment notification, phone messages, emails, birthday or holiday cards, information about our clinic, or other health related information. I can revoke this authorization at any time in written form. All my records will be protected & will not be released to others without my consent.

\_\_\_\_\_ I am responsible for this account. I direct any insurance company, attorney, or other person who holds or later holders proceeds to apply it to my account at this clinic, as payment toward total charges for professional services rendered. I agree to pay in a timely manner, any balances of said applicable charges. I agree that this office be given power of attorney to endorse all drafts for payment of my bill. All copays and deductibles are due at the time of service. I understand that I will be responsible for any collection of court fees involved if the account must be sent to collections. I also certify that I am not using a false identity.

I understand that all the above is legally binding and that this contract can only be modified by addendum signed by both parties. If I do not understand or agree with any of the above, I will discuss this will my doctor. I will not sign below if I do not understand or agree to fully honor this agreement. I also intend that this agreement is permanent, irrevocable and binding. I have read, understand and agree to all the above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Patient’s Name Patient Signature (or parent/guardian) Date