ACTION CHIROPRACTIC
AND SPORTS INJURY CENTER

- We do not leave detailed messages on answering systems or with individuals other than you unless otherwise specified. We will only notify you to contact the office.
- We will only use your email to inform you of helpful information concerning my practice.
- Your information is confidential and will not be released to anyone.

Patient Injury or Chief Complaint: _____

Patient Name:_____ **Date of Birth:**_____

Phone Number: (H)_____(C)_____

Address: _____

City: _____ **State:**_____**Zip Code:** _____

Email Address: _____

Best Way to Reach You: Text message Cell House Email Other: _____

Instagram _____**Snapchat**_____ **Twitter** _____

Smoking Status: Everyday Occasionally Past Never

Allergies: _____

Current Medications and Dosage			

Please circle chosen method of payment (choose one only):

Insurance **Time of service discount/"Private pay"** **Other_____**

Insurance:

Insurance Company: _____**Employer:** _____

Name of Policy Holder: _____

Policy Holder Date of Birth:_____**Relationship to Patient:**_____

ID Number: _____ **Group Number**: _____

Secondary Insurance:_____**ID number**:_____**Group**:_____

Please continue onto the next page

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Demographics:

Our practice utilizes a certified Electronic Medical Record software system that is in compliance with Medicare. Medicare regulates the entire health insurance industry. Because we are a participating provider for several insurance carriers, we are required to ask the following information from everyone:

Please circle those that apply to you:

Preferred Language: English Spanish Other: _____

Ethnicity/Race: I decline to provide White African American Asian

American Indian or Alaska Native Native American or Pacific Islander

Hispanic or Latino Other: _____

Sexual Orientation: I decline to provide Straight Lesbian Gay Bisexual

Other: _____

Emergency Contact Information:

Contact Name: _____

Relationship to Patient: _____ **Phone Number:** _____

Who May We Thank for Referring You?

_____

Office Policies:

- Cancellations, No Shows& Late Arrivals –
  - **ALL** "no-shows" or cancellations made with less than 24-hour notice **WILL** be charged a **$30.00 fee**.
  - This is expected prior to receiving treatment at you next appointment.
  - If you are more than 10 minutes late and wish to cancel, you will be subjected to a $30.00 late fee. If you wish to receive therapy, your session will be limited to the remainder of your scheduled appointment.
- Cell Phones –
  - Out of respect and courtesy for other patients as well as for our front desk staff, please silence your phone and take calls out of the waiting area.
- Digital Consent-
  - There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right? If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website.

Please sign in the space provided to indicate you have read, understand, and will comply with these policies

Signature: _____ **Date:** _____

Please continue onto the next page

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Consent to be Treated

Please read the following and sign in the space provided indicating you understand the information.

A patient willfully choosing to be treated by the chiropractic physician gives the doctor permission and authority to care for him/her in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures, including physical therapy, are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. In no way will the treating chiropractor provide treatment or care if he/she is aware that such care may be contra-indicated.

It is the responsibility of the patient to make it known, or to learn through health care procedures whatever it is he/she is suffering from; latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractic physician. The physician provides a specialized, non-duplicating health care service.

Furthermore, any risk involved regarding chiropractic treatment will be explained to you upon your request. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

Consent to be Treated:

Signature: _____ **Date:** _____

Signature of Parent/Legal Guardian:_____ **Date:** _____

Appointment Reminder Authorization :

I, _____, authorize Action Chiropractic and Sports Injury Center to send Appointment Reminders electronically via text message to my mobile phone and/or email. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number:

PATIENT NAME: MOBILE#:

_____ _____

_____I do NOT consent to appointment reminders via text message. Please provide preferred appointment reminder:

Voice/phone call _____ Email _____

Please continue onto the next page

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Financial Responsibility

Please read the following, initial and sign in the space provided indicating you understand the information.

Verify andcircle chosen method of payment:

Health Insurance **Time of service discount/"Self pay"** **Other** _____

Health Insurance:

I, the undersigned, have insurance and/or employee health care benefits coverage and herby assign and convey directly to Action Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to be 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.Your insurance is a contracted agreement between yourself and/or your employer, and the insurance company. Your insurance policyis YOURS, not ours. We verify insurance coverage for our billing purposes only. Upon verification we will notify you of any special circumstances; however, it is ultimately your responsibility to be aware of your coverage and any limitation(s).We are NOT responsible for the extent to which your insurance company covers our fees. Please read your explanation of benefits mailed by your insurance to your home. This document assists you in tracking your chiropractic coverage details. We do not track individual patient policy information.

Time of service/Private Pay:

Action Chiropractic reserves the right to change service and treatment fees at any time. You may contact our office to verify our current fee schedule prior to making an appointment or receiving services. Private Pay patients are offered a "courtesy – time of service discount". This fee is required at the completion of each treatment session.

In accordance with health insurance regulation**, our practice is not permitted to collect the private pay fee from you AND submit to the insurance company simultaneously.** Your financial status is in "health insurance" OR "private pay" only. If at any time you wish to use your health insurance, any past treatment and fees are not eligible for submission. Upon changing your financial status to insurance, only that date of service and future dates of service are eligible for submission.

Automobile Accidents/Workers Compensation:

Our office will generate the claims for your treatment and forward those claims to the responsible party using the claim number and billing information you provided. Please understand that your claim number and claim submission are never guarantee of payment. The responsible agency will request documentation of your treatment and progress for which we are required to provide. Upon completion of their medical review, a determination will be made, and payment will be generated. Any treatment cost that exceeds benefit levels you were quoted or are denied is patient responsibility.

Outstanding balance fee

I understand an additional fee will be added to unpaid balances over 120 days and balances headed to collections.

Signature: _____ **Date:** _____

Signature of Parent/Legal Guardian: _____ **Date:** _____

Please continue onto the next page

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HIPAA Acknowledgement /Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

Please continue onto the next page