

# Patient Confidentiality Info --- Terms of Acceptance

Patients Name: _____	Chief Complaint: _____
Address: _____ _____	Home Phone: _____
SSN _____ / _____ / _____	Cell: _____ Work: _____
Date of Birth: _____	Email: _____
Occupation: _____	Marital Status: M S W D
Referred by: _____	Employer: _____
ID#: _____ Group#: _____	Ins. Company: _____
Name of Insured: _____	Ins. Phone: _____
	Have you been to a Chiropractor before? Y or N

Please read below and if you have any question please feel free to ask one of our staff members.

### Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. 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. I understand that if I am accepted as a patient Ollis Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

### Women Only:

To the best of my knowledge (**I am / am NOT pregnant**) and (**give my permission / do not give my permission**) to x-ray me for diagnostic interpretation. (**Please circle answer that best applies to you.**)

### 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.

### Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so? (Please provide names.)

Spouse: \_\_\_\_\_ Children: \_\_\_\_\_ Others: \_\_\_\_\_ None: \_\_\_\_\_

### Missed Appointments:

**There is a possible \$40 fee charged for all appointments that are not canceled 24 hours prior to scheduled visit. \_\_\_\_\_ (initial)**

### Assignment of Benefits and Release

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 and convey directly to Ollis Chiropractic 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.

### Acknowledgement

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_