KING CHIROPRACTIC

King Chiropractic Patient Intake and Consent Form					
First Name		Last Name		MI	Date
DOB	Age	Sex	Email		Marital Status
Address			City	State	Zip
Phone		Emergency Contact			
Emergency Contact Phone			Relationship to Patient		
How did you hear about us?			Primary care doctor:		
Primary Insurance					
Insurance Company			Policy Holder Name		
Insurance ID			Group #		
Plan Name			Phone #		
Address			Unit/Suite		
City		State		Zip	
(Office Use) Policy Effective Date(s)			Payer ID		
Co-pay $	Co-Insurance $		Deductible $		Visit Limit
Reason for your visit					
☐ Wellness or Maintenance Only (no pain)		☐ Injury, Pain Complaint or Ailment			Date Started:
Please provide brief details about your complaint:					
Pain Scale from 0-10 (10 being the worst possible):					

Were You Involved in an Accident? (If no skip this section)			
☐ Motor vehicle	☐ Other type of accident	Date of Accident	State occurred
Lifestyle			
Do you use tobacco? ☐ Y ☐ N	If yes, how often?		
Do you drink alcohol? ☐ Y ☐ N	If yes, how often?		
Do you exercise? ☐ Y ☐ N	If yes, how often?		

Have you ever been hospitalized? ☐ Y ☐ N	Have you had any surgeries? ☐ Y ☐ N
If yes, please describe dates and details:	
Do you have allergies? ☐ Y ☐ N	Do you require medical treatment for allergies ☐ Y ☐ N
If yes please describe:	
Do you take any medications? ☐ Y ☐ N	Do you take and supplements? ☐ Y ☐ N
Please list medications and supplements:	
Please provide any other medical information you feel the doctor needs to know	

Patient Signature	**Date**
Guardian Signature	**Date**

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

Patient Health Information and Privacy policy: This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHU to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has a right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patient have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **King Chiropractic** for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **King Chiropractic** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **King Chiropractic** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. In doing so, the patient understands, acknowledges and affirms that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. The patient may refuse treatment at any time.

Treatment of minors: If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on premises during any such treatment and waive any claim I may have resulting from failure to do so.

Liability: I know and agree that King Chiropractic is not responsible for loss or damage to personal valuables.

Waiver and Release: I hereby release, discharge and acquit King Chiropractic, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician physician or urgent care services.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature **Date**

Guardian Signature **Date**