CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

DATE ___/___/___

PATIENT INFORMATION:

FULL NAME_____ DATE OF BIRTH ___/___/___ AGE ___ Male☐ Female☐

ADDRESS_____ APT#_____ SSN ____ - ____ - ____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (_____)_____

ALTERNATE PHONE (CELL): (_____)_____ EMAIL ADDRESS: _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE ____ ZIP _____

WORK PH. # (_____)_____ EXT._____ DATE SYMPTOMS BEGAN: ___/___/___

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____PHONE_____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐

TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐

I WILL BE PAYING TODAY BY CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____

INSURED'S EMPLOYER SAME AS ABOVE ☐ _____

INSURED'S SSN SAME AS ABOVE ☐ SSN ____ - ____ - ____ INSURED'S DOB SAME AS ABOVE ☐ ___/___/___

PRIMARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

****

SECONDARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

AUTHORIZATION, ASSIGNMENT, ACKNOWLEDGEMENT AND UNDERSTANDING

Authorization to release information: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow McLeod Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Assignment of Payment: My attorney and/or insurance company are hereby requested to pay direct to McLeod Chiropractic Center any monies due on account, the same to be deducted from any settlement made of my behalf. Furthermore, it is understood that I, the undersigned, agree to pay the full amount of the charges, should my condition be such that is not covered by my policy, or, if for any reason, the insurance company and/or attorney refuses to pay my claim.

Medicare Assignment: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Consent to care for a minor: I hereby authorize McLeod Chiropractic Center to administer care as deemed necessary to:

_____
Child's name

I hereby acknowledge that I am receiving (or are about to receive) health care services at McLeod Chiropractic Center and that I have been advised that McLeod Chiropractic Center is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

A. that there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to McLeod Chiropractic Center or to make other provisions for the protection of the interest of McLeod Chiropractic Center, or

B. a liability claim exists and my attorney refuses to agree to protect the interest of McLeod Chiropractic Center, or if I have not engaged the services of an attorney:
then payment of services at McLeod Chiropractic Center will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

_____ _____
Patient Name Patient Signature

_____ _____
Date Signed Witness

PROFESSIONAL COURTESY

As a professional courtesy, I authorize McLeod Chiropractic Center to provide my medical doctor with a report for my medical record. Please send to:

_____ _____
Name of Medical Doctor Office Name

_____ (___)_____
Office Address Telephone

_____ _____
Patient Name Patient Signature

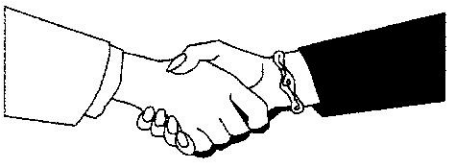
Patient Health Information Consent Form

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 HIPAA 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 Patient Health Information (**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 or 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 effect 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 official 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.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date



Terms of Acceptance

When a patients seeks chiropractic health care, and when a chiropractor accepts a patients for such care, it is essential that they both be seeking and working for the same goals.

Chiropractic has one goal. It is important that a patient understand this goal and the means that it will be used to attain it. In this way there will be no confusion, misunderstanding or disappointment.

Patients usually want their conditions, ailments or symptoms treated. This is not the goal of the chiropractor. The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine called vertebrae. Tiny misalignments of the vertebrae, which interfere with the functions of the nerve pathways are called subluxations. They come from many causes and prevent the body from working properly.

By means of chiropractic adjustments, subluxations are corrected, restoring normal nerve function. The goal of chiropractic is to correct these subluxations so that every part of the body may have a proper nerve supply at all time. This allows the innate healing ability of the body to work at maximum efficiency.

With the proper nerve supply, health improves. In some cases, symptoms clear up quickly, for others, the process is slower: in some it is only partial, or not at all.

Regardless of the disease, the chiropractor is not offering to diagnose, treat or cure it. His goal is to allow the body to do its job as best it can without nerve interferences. This goal is accomplished by the correction of vertebral subluxations.

The chiropractic examination and adjustment are not substitutes for other types of health care, just as other types of care do not take the place of chiropractic.

At the McLeod Chiropractic Center, we utilize "Open Room Adjusting" in which multiple adjusting tables are side by side and you will often be treated while other patients are in the room. We have found this arrangement has many benefits for our patients. The greater efficiency allows us to greatly shorten waiting time (most days you will not have to wait at all) and the doctor's advice on healthy living is beneficial for all to hear. Personal or embarrassing topics will not be discussed in this open forum but anything you discuss with the doctor can and will be overheard by other patients.
If you wish to discuss a private matter with the doctor, please notify a team member at the front desk so you may be seen separately. It is not necessary for you to tell the team member the subject of this discussion.

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

_____ _____
signature date

Appointment Reminders and Health Care Information Authorization

Your Chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Also, by signing this form, you are giving authorization to use your basic information, such as: name, address, phone number, email address, etc. to use for communication and/or appreciation services such as: birthday cards, referral boards, USPS and/or email newsletters, notices/letters, appointment reminders, reactivation letters, etc.

You may restrict how your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of the date printed below. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above.

_____ _____

Name(Print) Date

_____ _____

Signature Authorized Provider Representative