PURE CHIROPRACTIC & REHAB

Whom may we thank for referring you? _____

Gender
◯ Male ◯ Female

Your Last Name _____ **Your Social Security Number** _____

Your First Name _____ **Your Middle Name (Or Initial)** _____ **Birth Date (MM/DD/YYYY)** _____ **Height** _____

Address _____ **Apt #** _____ **Weight** _____

Marital Status
◯ Single
◯ Married
◯ Separated
◯ Divorced
◯ Widowed

City _____ **State** _____ **ZIP/Postal Code** _____

Ethnicity
◯ Latino
◯ Non-Latino

Phone _____ **Cell Provider** _____

Email _____ **Employer** _____ **Employer Phone** _____

Race
◯ Caucasian
◯ African American
◯ Hispanic
◯ Asian/Pacifica Island
◯ Native American

Spouse's Name _____ **# of Children** _____

Emergency Contact _____ **Phone** _____

Have you been treated by a chiropractor before? ◯ Yes ◯ No

If yes, what was the reason _____ **Approximate date of last visit?** _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called, texted, or emailed to confirm or reschedule an appointment.**

Initials _____ **I grant permission to leave appointment information on voicemail or with person that answers the phone.**

Initials _____ **I grant permission to be sent occasional cards, letters, emails, or health information relating to my care.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I may request a copy of the Financial Policy at any time.**

With whom may we discuss your medical condition/billing questions and/or your child's medical condition/billing information/questions other than yourself?

1._____ Phone #_____

2._____ Phone #_____

_____ _____
Signature Date (MM/DD/YYYY)

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____
Signature Date (MM/DD/YYYY)

Chart No_____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including various modes of physiotherapy, chiropractic adjustments, examinations, and any supportive therapies performed on me (or on the patient named below, for whom I am legally responsible) by *Pure Chiropractic and Rehab* and/or other licensed providers and support staff who now or in the future will deliver treatment.

I understand and I am informed that, as is with all healthcare treatments, 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. I do not expect the provider 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 treatment which the doctor feels, based upon the facts then known, is in my best interest.

I further understand that treatment is designed to improve 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. 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.

Notice of Privacy Policy - I understand I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessment and accreditation. I understand that by signing below, I am getting written consent for the use and disclosure of protected health information for treatment, payment, and healthcare operations. If you would like a copy of our Notice of Privacy Policy one is available at the front desk.

Office Financial Policy

I acknowledge payment is due at the time of treatment, unless other arrangements have been made. I accept full financial responsibility for all charges related to services and items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I understand that I am responsible for any amount not covered by my insurance. I understand filing a claim with the insurance does not relieve me from responsibility to pay all charges. I also agree that I will be responsible for any collection agency or attorney fees incurred.

1. **If you do not have insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time. Our payment plans make care an affordable part of your family budget.
2. **If you have insurance:** All copayments are expected at time of service or by an authorized payment plan. Your coinsurance balance may not exceed $100. We will forward claims to secondary insurance carriers if information is provided. Our payment plans make care an affordable part of the family budget.

You are considered a cash patient until you bring in your insurance information, and we qualify and accept your insurance coverage. Our fees are considered usual, customary and reasonable in most companies and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If your carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within 90 days of submission, you are responsible for payment in full of any outstanding balance.

Patient's Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Clinic Witness: _____ Date: _____

Chart No_____