

CONFIDENTIAL DATA

NAME: _____
(FIRST) (MI) (LAST)

CALLED NAME (NICKNAME) _____

ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP _____

PRIMARY PHONE _____ (CIRCLE ONE: CELL HOME OTHER _____)

ALT. PHONE _____ (CIRCLE ONE: CELL HOME OTHER _____)

EMAIL _____ MARITAL STATUS: S M W D

DATE OF BIRTH _____

HOW DID YOU LEARN ABOUT THIS CLINIC? _____

EMERGENCY CONTACT: _____
(NAME) (PHONE) (RELATIONSHIP)

SIGN AND DATE X _____ X _____

INSURANCE:

PRIMARY INSURANCE COMPANY NAME _____

SUBSCRIBER NAME: _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE NAME (IF APPLICABLE) _____

SUBSCRIBER NAME: _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: _____

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. This information is provided so that you can make an informed decision to undergo such care, and can knowingly give or withhold your consent.

A **vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. The primary goal of chiropractic care is the removal/reduction of nerve interference caused by subluxations through adjustments. The **chiropractic adjustment** is the application of a precise movement and/or force into the spine (or other joint) in order to reduce or correct the subluxation(s). There are different methods of delivery, but adjustments are typically performed by hand. Other methods and procedures may be included in the treatment protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

RISKS OF CHIROPRACTIC CARE: All medical care has associated risks. Chiropractic is no different. Risks include soreness, muscle and/or joint pain, musculoskeletal sprain/strain, and fracture. The most serious risk associated with chiropractic care is stroke or cardiovascular incident. The risk is minimal when compared to other medical treatments. The risk is calculated to be one in two million adjustments.

We are not able to promise complete recovery. We will use our best efforts and most effective therapies to provide you the best possible results. If your symptoms do not respond to treatment within a reasonable amount of time, we will suggest other avenues of therapy or refer you to an appropriate doctor. Examples include primary care physician, orthopedic surgeon, neurologist, physiatrist, physical therapist, acupuncturist, or massage therapist.

I have been informed of the nature and purpose of chiropractic care, the possible outcomes of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THE CHIROPRACTORS OF LEATH CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

PRINT Patient Name and Date of Birth

SIGN Patient (or legal guardian)

Date

HIPAA Compliance Patient Consent Form

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to privacy in regard to your protected healthcare information. You may request to see our full privacy policy at any time. You ascertain that by your signature that you have reviewed and/or declined to review our notice before signing this consent.

By signing this form, I understand that:

- It gives consent to the clinic’s policies of use and disclosure of the patient’s protected healthcare information and potentially anonymous usage in a publication.
- The patient has the right to review their records.
- The patient has the right to restrict the use of the information. However, HIPAA still allows for the use of the information for treatment, payment, or healthcare operations. You give permission to Leath Chiropractic LLC to release any information deemed appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred at Leath Chiropractic LLC by me.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. Such a revocation will not be retroactive.

I give my permission to Leath Chiropractic to:

- Send text alert reminders for my appointments. YES NO
- Leave a *detailed* message. YES NO
- Discuss my medical condition and/or account balance with (specified) others. YES NO

If YES, please list the people we are allowed to share with, and any restrictions on what may be discussed:

PRINT: Patient Name & Date of Birth _____

AND

SIGN: Patient (or Legal Representative) Signature: _____ Date _____

If you are patient’s representative, describe relation/authority to act on their behalf (ex: parent, legal guardian, PoA)

FINANCIAL POLICY:

- The patient portion of the balance (such as copay, deductible prepay, or full balance for those without insurance) is due at the time of service unless arrangements have been made in advance. We collect *an estimate* each visit for deductibles. Remaining balances (deductibles, co-insurance, non-covered/denials) are due after claim processes.
- If a third party, such as an insurance company, is expected to pay the fees, it is the patient's responsibility to provide accurate, current information and alert staff of changes. While we verify benefits as a **courtesy**, it is the patient's responsibility to be aware of the benefits & limitations of their plan.
- Benefits quoted by insurance are not a guarantee of coverage. Insurance companies reserve the right to make the final determination of coverage at the time of claims processing. Please understand that any differences between what was quoted and how it processes are beyond the clinic's control.
- If your insurance policy requires a **referral** from another doctor, or **preauthorization** from insurance, you **MUST** obtain the referral before your appointment. It is **your responsibility** to know if one is required and secure it.
- **The fees for service are ultimately the responsibility of the patient, regardless of insurance coverage.** You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim for any reason, reverses payment at a later date, or you elect to continue treatment past your benefit limit, you will be responsible for your account balance in full. If you request that we submit services we don't believe will be covered, understand that you take the financial risk and will owe the balance if they don't pay for any reason.
- **HSA, HRA, and FSA accounts:** If you have one of these funds, please be aware that disputes with your fund are separate from your account with us. Your bill is still due, even if they aren't releasing funds. We are happy to provide receipts for you to submit for reimbursement, but your account will become overdue if you stall payment while appealing their denial. We can also wait and run your HSA card for the exact amount if kept on file (see below).
- We do our best to work with patient's financial situations. Our primary concern is that you can continue care as long as you need it. If you can't pay in full, we are happy to work out monthly payments. Accounts become delinquent if no payment is received over 90 days from the first billing cycle and may be turned over to collections.

I have read the above policy regarding my financial responsibility to Leath Chiropractic for providing treatment. I certify that any insurance information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to assign all benefits payable directly to Leath Chiropractic. I understand the financial responsibilities laid out in this form, and I agree to abide by them.

We can securely save your credit/debit card on file. (HSA card - please tell us. We can charge deduct/coinsurance when claim processes) **CHECK ONE:**

_____ Save my card. I give permission to charge the card for balance due if I am not present. Receipt available upon request.

_____ Save my card. I do not give permission to use my card if I am not present. I understand that if my account is delinquent, my card still will be charged to avoid possible collections. I understand that attempts will be made by staff to contact me first.

_____ I do not want to save my card on file.

Patient Name **X** _____ (PLEASE PRINT) Date: **X** _____

SIGN: **X** _____ Relation to Patient: _____

I, _____, am the **guarantor** for payments on this patient's account. This remains active until I cancel in writing. Please send bills to the following address: _____