PATIENT DATA SHEET

CHIROPRACTIC HEALTH & WELLNESS CLINIC

General Information

First Name _____
Middle Initial _____
Last Name _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
Sex Male Female
Race American Indian, Alaska Native, Asian
Black or African American, Native Hawaiian,
Other Pacific Islander, White, Declined to State
Ethnicity Declined to State, Hispanic or Latino
Not Hispanic or Latino
Language _____
Marital Single, Legally Separated, Married, Widowed, Divorced
Birthdate _____
Social Security _____
Referred By _____
Work Status Employed Full-Time Student Part-Time Student
Appt Reminder _____

Informed Consent

Dr. Giddings will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculo-sympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

If patient is a minor or under a guardianship order as defined by State law:

By_____ _____
Patient's Signature Date Signature of Parent/Guardian (circle one) Date

Consent to Treatment of Minor Child

Consent to Treatment of Adult with Medical Power of Attorney

I hereby authorize Dr. Giddings and whomever he/may designate as hisassistants to administer treatment as he so deems necessary to _____ (Name of Patient).

_____ _____ _____
Printed Name of Person Authorizing Treatment Signature Date

Relationship to Patient _____

IF YOU ARE CONSENTING ON BEHALF OF AN ADULT, DO YOU HAVE MEDICAL POWER OF ATTORNEY? _____ (Please provide our office with a copy of the medical Power of Attorney). Witnessed: _____

OFFICE FINANCIAL POLICY

CASH

All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.

We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

Whenever you receive any worksheets form your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any overpayment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

If the patient is referred to another specialist or discontinues care for any reason other than discharged by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.

If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing Dr. Giddings.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms

_____ _____

Patient's Signature Date