ALIGN
CHIROPRACTIC

First Name_____ Middle_____ Last_____

Gender __ Male __Female Home Phone_____ Cell Phone _____

Address_____

City _____ State _____ Zip _____

Social Security Number _____ Email Address_____

Birthdate_____ Age _____ Marital Status S M W D

Job Title _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Social Security Number _____

Person responsible for this account _____

Name of the person on your health insurance card _____

Name of their employer _____ City _____

Employer Phone _____

Children- Names & Ages _____

_____

In case of emergency, whom should we contact? _____

Phone/Relation to patient _____

Family Physician: _____

What is your Primary Complaint? _____

Patient Informed Consent

I, _____, the undersigned, consent to care at this office. I understand that I have the opportunity to discuss with the chiropractor and/or other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Align Chiropractic. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are not limited to, aggravating and/or temporary increase in symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the chiropractor to be able to anticipate and explain all risks and complications, and I wish to rely on the chiropractor's judgement, based upon the facts then known, and 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 though a conservative approach with hopes to avoid more invasive procedures.

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.

Guardian/Patient Signature_____

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Updated Medicine, Vitamins and Allergy History

Patient Name: _____ Date of Birth: _____

Active Medication List (please include dosage):

Active Vitamin List (please include dosage):

Active Allergies (Medication, Environmental, Food, etc):

Smoking History:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Patient Signature: _____ Date: _____

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Authorization for Release of Records

1. I authorize the professional staff of _____ to disclose the following patients' specified information to the professional staff of **Align Chiropractic.**

Patient Name: _____
Address: _____
Date of Birth: _____/_____/_____
Phone Number: _____
Social Security #: _____

2.Information to be released: ☐ Please FAX ☐ Please mail hardcopy

_____Complete health record
_____History and Physical Exam
_____Progress Notes
_____Radiology Reports
_____Radiology Films
_____Laboratory Reports
_____Other _____
_____Discharge Summary
_____MRI of _____
_____Consultation Reports
_____HIV Test Results
_____Psychiatric Records
_____Drug Screen, blood, alcohol

I understand that if complete health record is checked above all medical information will be releases including psychiatric records, alcohol or drug screening and HIV test results.

3. This information is to be disclosed to: **Dr. Ashley Bills**

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken thereon. This authorization will expire 90 days from, the date of authorization.

Access to medical information is the right of every patient; duplication and distribution is a service. Releases are subject to copy and distribution cost. I understand the potentiality of charge for the service and release of medical information and accept financial responsibility.

_____ _____/_____/_____

Signature of patient **Date**

_____ **Please Print Name**

_____ _____/_____/_____

Signature of Legal Guardian **Date**

_____ **Please Print Name**

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Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, Align Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT'S / GUARDIAN'S SIGNATURE

INSURED'S SIGNATURE

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Align Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

PATIENT'S / GUARDIAN'S SIGNATURE

DATE

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HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of our protected heath information (PHI) and to provide you with a Notice of Privacy Practices. Our Not of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering us a written, dated document signed by you. However, such a revocation shall not affect any disclosers we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment or health care operations or certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or **SPAM** your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon execution of this Consent.

The Consent was signed by: _____

Printed Name- Patient or Representative

_____

Signature Date

Relationship to Patient

(if other than patient) _____

Witness: _____

Printed Name- Clinic Representative

_____

Signature Date

For Internal Use:

Patient Refused to Sign ○ Patient unable to sign for following reason: _____