Welcome to Advanced Chiropractic Specialists

Confidential Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. Make sure you complete both sides and sign your name on the back. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Date _____ e-mail Address: _____ Cell Phone _____

Name _____ Sex _____ Marital Status _____ D.O.B. _____ Age____ Home Phone _____
First, Middle, Last | M or F | Mo/Day/Yr | Area Code/Number

Address _____ City _____ State _____ Zip Code _____
Include Street type such as St., Ave., etc.

_____
Social Security # | Business Phone Number | Company Name | Location

_____
Spouse's First Name | Spouse's Social Sec # | Spouse's Employer | Location

Name of nearest relative (not living with you): _____ Phone:_____

Whom may we thank for referring you to us? _____

Primary Care Physician: _____ **Phone**:_____
Area Code/Number

Were you referred to a certain doctor in this office? _____

Is your visit due to an accident? ☐ No ☐ Yes, Date _____ (If yes, please see receptionist for an injury report.)

If yes, is this accident work related? ☐ No ☐ Yes, Date _____

My bill will be paid by: ☐ Cash ☐ Medicare ☐ Worker's Compensation ☐Attorney Lien ☐ Health Insurance ☐ Other Ins.

Insurance Company_____ Group/Policy No. _____

Responsible Party and/or Primary Insured: Name _____ D.O.B _____
First, Middle, Last | Mo/Day/Yr

Social Security # _____-_____-_____ Home Phone _____Cell Phone _____
Area Code/Number | Area Code/Number

Address _____ City _____ State _____ Zip _____
Include Street type such as St., Ave., etc.

I understand and agree that health and accident insurance 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. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Advanced Chiropractic Specialists extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I understand if I default on any portion of the amount owed, I agree to pay any and all reasonable collection fees and attorney fees as prescribed by law. I hereby authorize the doctors at Advanced Chiropractic Specialists and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____ Date_____

Authorization and Assignment

To: Dr. _____

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim reimbursement of charges incurred by me as a result of professional services rendered by you and I hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the names of which are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect from insurance proceeds (whether it be all or part of what is due.) I personally owe you and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

To:_____
Name of Attorney and/or Insurance Company

In consideration of the chiropractic services rendered (and to be rendered.) I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe; by you, my attorney, out of the proceeds of any settlement of my case, (any settlement for services by Advanced Chiropractic Specialists, requires the doctor's prior written agreement) and /or by any insurance company obligated to reimburse me for the charges for services or otherwise obligated to make payment to me or to my Chiropractor based in whole or in part upon the charges made for those services.

Acknowledgment and Understanding

I hereby acknowledge that I am receiving (or are about to receive) health care services at Advanced Chiropractic Specialists, and that I have been advised that the doctor providing the services by Advanced Chiropractic Specialists, requires the doctor's written agreement. 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 the doctor or make other provisions for the protection of the interest of the doctor, or

(B) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment for services rendered by the doctor at Advanced Chiropractic Specialists 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.

I further understand that if I default on any portion of the amount owed, I agree to pay any and all reasonable collection fees and attorney fees as prescribed by law.

Date:_____ Witness:_____

Patient's Printed Name:_____ Patient's Signature:_____

Advanced Chiropractic Specialists

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctors at Advanced Chiropractic Specialists and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed or any other branch office or clinic.

I will have an opportunity to discuss with a doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to localized tenderness, headache, sprains, fractures and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Legal Guardian Signature _____ Date _____

Patient Printed Name _____

Legal Guardian Name <if applicable> _____

Witness Signature _____ Date _____

ADVANCED CHIROPRACTIC SPECIALISTS

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing Advanced Chiropractic Specialists as your chiropractic health care provider. We appreciate the opportunity to assist you with your chiropractic needs.

The following is our financial policy. We believe that having financial matters clear, from the onset, is preferable to encountering difficulties later.

1. INSURED PATIENTS: Co-payments and/or deductibles are **due at the time services are rendered.**
2. CASH PATIENTS: Payments for services are **due at the time services are rendered.**
3. **We accept CASH, PERSONAL CHECK, and MOST CREDIT CARDS for your convenience.**
4. We will bill your secondary insurance as a courtesy to you, but we will only bill them **once.**
5. If your insurance company does not pay your claim within 30 days, we ask that you contact your insurance company. If your insurance company does not pay in full within 60 days, we require you to pay the balance due with cash, check or credit card.
6. All charges are your responsibility whether your insurance company pays or not. Not all services are covered by insurance; some insurance select certain services that they do not cover. You are responsible for knowing what is not covered by your insurance. Payment for these services is due when treatment is rendered.
7. It is your responsibility to verify that the doctor you are seeing is a provider for your insurance.
8. You are responsible for any and all collections fees, legal fees and court costs associated with efforts to collect payment on your account.
9. **Our office does require a 24 hour cancellation notice in order to avoid a minimum fee of $25.00 being charged to your account.**
10. **A returned check will be subject to a $30.00 returned check fee.**

Thank you for your cooperation.

I, _____ have read and understand the above policies.
(Patients Printed Name)

Patients Signature: _____ Date: _____

ADVANCED CHIROPRACTIC SPECIALISTS

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and have been provided an opportunity to review it. _____ (initial)

I further give consent to Advanced Chiropractic Specialists to release information concerning my medical condition to the following person(s):

Printed Name of Individual(s)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name _____ Birthdate _____

Signature _____

Date _____