AKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

PERSONAL INFORMATION:

Last: _____ First: _____ M.I.: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Date of Birth: _____ Marital Status: M D S W Social Security #: _____

EMPLOYMENT INFORMATION:

Employer: _____ Student?: Y N

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

PRIMARY CARE PHYSICIAN:

PCP Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

PRIMARY HEALTH INSURANCE:

Insurance Company Name: _____

Name of Insured Member: _____

Insured's Date of Birth: _____

Insured's Employer: _____

Insurance Identification Number: _____
(PLEASE INCLUDE PREFIX/SUFFIX)
Insurance Group Number: _____

SECONDARY HEALTH INSURANCE:

Insurance Company Name: _____

Name of Insured Member: _____

Insured's Date of Birth: _____

Insured's Employer: _____

Insurance Identification Number: _____
(PLEASE INCLUDE PREFIX/SUFFIX)
Insurance Group Number: _____

Last: _____ **First:** _____ **M.I.:** _____

PLEASE READ CAREFULLY AND SIGN THE AKNOWLEDGEMENT WHERE NOTED:

CONSENT TO THE RELEASE OF MEDICAL INFORMATION:

- I authorize the release and disclosure of any and all of my medical records to any other entity including, but not limited to, referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office in providing for the treatment of the patient.
- I authorize this office and it's employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be, liable for all or any part of the provider coverage.
- I authorize the release of medical records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office and it's employees to release via fax and/or electronic/internet transmission medical records, which are needed in order to provide the patient with the appropriate medical care.

CONSENT TO FINANCIAL RESPONSIBILITY:

- All fees are due and payable at the time when services are rendered unless one of the following applies to you:
  1. You were injured at work and are filing a Workers' Compensation claim.
  2. You were injured in a Motor Vehicle Accident and are filing a No Fault claim.
  3. You have health insurance that provides coverage for chiropractic care.
- We will accept direct assignment of your claim <u>if it is allowable</u>. However, please know that you will still be responsible for any non-covered services, such as deductibles, co-pays or co-insurance, etc. If your claim is denied, please know that you will be responsible for the services rendered.
- You are responsible for the office visit charge unless at least 24 hours of notice is given prior to cancellation.
- You are responsible for charges incurred from an overdrawn account. It is our policy to charge a fee of $20, in addition to the billing charges for incurred bank surcharges.

CONSENT FOR THE ASSIGNMENT OF BENEFITS:

- I authorize direct payment of medical benefits to this office from the listed insurance carrier. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

AKNOWLEDGEMENT OF ACUTE VERSUS WELLNESS CARE:

- Please note that most insurance carriers do not cover "wellness" or "preventative" care. If you are not suffering from a health condition that necessitates care, and if your insurance carrier does not offer wellness or preventative coverage, your claim may be denied and you will be responsible for the charges.

I consent to the release of my medical information. I understand my financial responsibility, that my insurance may not cover wellness & preventative care, and I consent to the assignment of benefits: **X**_____ **DATE:** _____

CONSENT FOR EXAMINATION AND TREATMENT:

- I hereby authorize Dr. Brian C Vetter, an authorized covering doctor, and/or chiropractic assistants to perform upon me, the patient, the following course of treatments as deemed necessary by the doctor. These therapies include, but are not limited to, Chiropractic Manipulative Therapy, Myofascial Therapies, Exercise Therapies, Cryotherapy, Thermal Therapy, Electrical Stimulation Therapy, Ultrasound Therapy, Nutritional Therapy, and other therapies allowed under the scope of Chiropractic care.
- Doctors of Chiropractic (DC) utilize manual therapy treatments. The complications of these therapies may include soreness, bruising, swelling, sprains, strains, dislocations, burns from physiotherapies, fractures, disc injuries, stroke (although a small and remote possibility, we need to inform you that the risk is 1:3 million), and other possible soft tissue injuries. I understand that during the course of the procedure unforeseen conditions may arise which necessitate procedures different from those initially proposed.
- I acknowledge no guarantees or assurances have been made to me concerning results obtained from the procedure and treatment.

I consent to examination and treatment **X** _____ **DATE:** _____

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

- I acknowledge that I have received a copy of this office's Notice of Privacy Practice and/or it is posted and available for me to read.

I acknowledge this office's Notice of Privacy Practice is available to me **X** _____ **DATE:** _____