

History Update

Name: _____ Birthdate: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Phone Carrier, AT&T, T-Mobile, Verizon, other _____

E-Mail: _____

Emergency Contact: _____ Relationship: _____ Cellphone: _____

ANY PACEMAKER, DEFIBRILLATOR, IMPLANTS, ROD, PLATE, SCREWS, PORTS _____

Updated Health History (Recent accidents, hospitalizations, or illnesses since your last visit):

List of Current Medications

Describe your current problem _____

When did the symptoms start _____

Described pain/discomfort (CIRCLE) ACHING, BURNING, SHARP, SORE, TIGHT, STABBING, STIFF

Is pain/discomfort primarily on one side (Circle) Right /Left /Bilateral

Have you seen anyone else for this condition _____, If so who? _____

Do you have spinal X-Rays, MRI, CT SCAN? _____

On a Scale of 1 to 10, with 10 the most intense discomfort, how would you rate your discomfort?

1 2 3 4 5 6 7 8 9 10
Good Bad

I certify that I have read the above information. I understand that providing inaccurate or incomplete information can be dangerous to my health. I authorize Fox Chiropractic Center to release any information pertinent to care rendered to my child or myself during the period of chiropractic care to third party payer and or to health practitioners. I authorize and request my insurance co. to pay directly to Fox Chiropractic Center insurance benefits otherwise payable to myself. I understand that my insurance carrier may pay less than the actual bill and that I am responsible for payment for all services rendered on my behalf or my dependents.

Patient Signature: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of notice may change, if so, you will be notified at your next visit to update Your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do. We shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information, payment and healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment or healthcare operations.

The practice reserves the right to change the privacy as allowed by law.

The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a voicemail message on your home or cell phone? YES NO

May we discuss your medical condition with a member of your family? YES NO

If YES, please name the member allowed and cell number:

Signature: _____ Date: _____

Witness: _____ Date: _____

Annual Financial Policy

Thank you for choosing Fox Chiropractic Center for your Chiropractic Care. We are committed to providing you excellent care.

Group Health/Liability Insurance

- **It is the patient's responsibility to provide us with current/accurate policy** information when using a health insurance carrier. As a courtesy we will bill your insurance within 10 days of treatment.
- Patient copays or any out of pocket expenses, including account balances (if any) should be paid at the time of your visit.
- Our office will, nor cannot, guarantee your insurance will pay for your services. **If your insurance claim is denied or if a service is denied or not covered, you will be responsible for your charges in full.** It should be noted your benefits are a contract between you and your insurance company and this office only serves as an intermediary. We will at no time enter into a dispute with your insurance carrier over your claim. This is your responsibility and obligation.
- Workers compensation, personal injury, and/or managed care may take additional time to process and the charges may accrue over time. In some instances there may be limitations on your policy and if you elect to continue treatment, under these provisions you will be solely responsible for the balance.
- **Most insurance does not cover acupuncture, massage and some other services. It is your responsibility to know what is covered by your insurance. You will be responsible for what they do not cover.**
- I hereby authorize any payment of benefits made directly to Fox Chiropractic Center. Additionally, I authorize the release of any medical information necessary to process the claims.

Cash Patient: Self Pay:

- Payment for Cash claims must be made at the time of service. Once entered into a cash agreement Fox Chiropractic will not, under any circumstance, bill any previous cash charges to another party or insurance company. Please review and understand our cash policy pricing with the front desk.
- I hereby authorize Fox Chiropractic to bill me directly for any services received at their facility. I understand I am responsible for payment of those services at the time of my appointment.

Print Name: _____ Date _____

Patient/Guardian Signature: _____