# Financial/Treatment Consent Form

Please sign and complete for treatment.

Chiropractic Care
wellness center

**Patient Information** Today's Date: _____

Name:_____ Date of Birth ____/____/____
Last First MI

Address: _____ City:_____

State_____ Zip: _____

Marital Status: Married Single Widowed Divorced

Soc. Security # _____/ _____/ _____ *(used as an additional insurance identifier)*

Employer_____ Occupation_____

# of years employed _____ Work Phone (____) _____

Home Phone (____) _____ Cell (____) _____

Preferred Reminders: Phone Call Email Text -*must* list cell carrier →_____

Email: _____

Emergency Contact _____ Phone (____) _____

*How did you hear about us?*

Friend/Family Patient Doctor Referral Internet Other_____

## CCWC Rules & Policies

We send appointment reminders as a courtesy to our patients.
Failure to receive reminder does NOT exempt a patient from the cancellation fee.

If patients fail to comply with our cancellation policy, which requires a 24-hour notice for all cancellations, they will be charged a **$30 fee**. The fee for massage appointments is **$50**; this will not be covered by your insurance company and is not payable with a HSA card.

In order to maintain a timely practice, Chiropractic Care Wellness Center staff reserves the right to cancel any appointment when a patient's arrival time is 5 minutes past their scheduled start.

Signed acknowledgment to above statements ***required***:

_____ ____/____/____

**Patient signature** **Date**

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## Payment Information

Circle One: Insurance Self-Pay Auto Accident Worker's Comp

## Insurance Information

**Primary Insurance**

Insurance Company _____ Effective Date _____

Member ID# _____ Group # _____

Policy Holder Name (if self, note self) _____ Policy Holder's Birthdate _____

Relationship to Insured: Self Spouse Child

**Secondary Insurance**

Insurance Company _____ Effective Date _____

Member ID# _____ Group # _____

Policy Holder Name (if self, note self) _____ Policy Holder's Birthdate _____

Relationship to Insured: Self Spouse Child

*Please inform office staff of any **additional** insurance not noted above*

_____ ____/____/____

**Patient signature** **Date**

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## Statement of Financial Responsibility and Authorization to Treat

I understand that I am financially responsible for all services rendered to me or my dependent at Chiropractic Care & Wellness Center. I hereby authorize the Chiropractic Care & Wellness Center & its successors to submit claims to my insurance company or another third party on my behalf. I further authorize my insurance company to direct payment to the Chiropractic Care & Wellness Center on my behalf.

***If my insurance company denies payment on my behalf, I understand that I am financially responsible for any remaining balance.***

Any balance resulting from a denial/rejection due to failure to provide accurate insurance information to CCWC staff will become your financial responsibility.

I authorize the physician to diagnose and treat me and/or my dependent/minor and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

## Self-Pay Policy

Payment is due at the time of service in order to receive a time-of-service discount.

**If payment is not collected at the time of service, then the responsible party will be charged the full amount of the service.**

_____ ____/____/____

**Patient signature** **Date**

## Authorization to Treat Cont.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy (or on the patient named below, for whom I am legally responsible: _____ by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Chiropractic Care & Wellness Center and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Darrin Taylor, 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 and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

## Patient Privacy Policy

The **HIPAA Privacy Rule** gives you a fundamental right to be informed of the privacy practices of our health plans, as well as to be informed of your privacy rights with respect to your personal health information. By signing this document, I acknowledge I have been offered a copy of the Notice of Patient Private Policy.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by the patient's representative/guardian:

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

Physician Signature _____ Date _____/_____/___

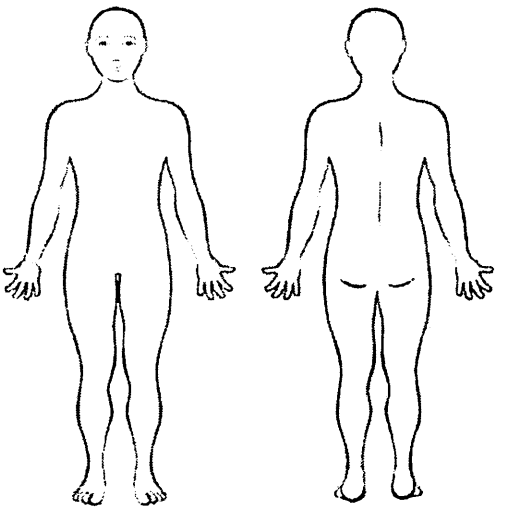
# PAIN CHART

Patient: _____ Date: _____

Mark the areas on the diagram where you feel the described sensations.
Use the indicated symbols with the correlating sensation and include *all* affected areas.

| Sensations: | Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|---|
| Symbols | ---------- | OOOOOOOO | XXXXX | ***** | /////// |

Height _____
Weight_____



Please ***write out*** which region of the body is affected separately on the numbered area lines below. Then **circle** the corresponding numerical value that indicates how much pain or discomfort you feel in that area.

**Area #1: _____**

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

**Area #2: _____**

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

**Area #3: _____**

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

**Area #4: _____**

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

## Please List Any Current Allergies, Medications, or Vitamins You Are Taking

| Allergies | Medications | Vitamins |
|---|---|---|
| ☐_____ | ☐_____ | ☐_____ |
| ☐_____ | ☐_____ | ☐_____ |
| ☐_____ | ☐_____ | ☐_____ |
| ☐_____ | ☐_____ | ☐_____ |

## Social History

**Cigarette Smoking:** Never Former: Quit Date_____ If you no longer smoke, how long did you smoke? _____
Current: Packs/Day_____ How long have you been smoking? _____

**Do you drink Alcohol?** No Yes Drinks per week? _____

**Exercise Habits?** Daily Weekly Never If yes, what type of exercise? _____

**Do you drink caffeine (coffee, tea, soft drinks)?** No Yes How many per day? _____

**Work habits include mostly:** Heavy Labor Light Labor Sitting Standing

## Past Medical History

| Past Injuries | Description | Date |
|---|---|---|

- Car Accidents: _____
- Dislocation/Fractures: _____
- Head Injuries: _____
- Hospitalization: _____
- Surgeries: _____
- Trauma: _____

Are you currently pregnant or is there a chance you may be pregnant? **Yes** **N**