Rock Chiropractic
Where miracles can happen

HIPPA COMPLIANCY

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have been notified and given the opportunity to read a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

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Terms and Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency chiropractic services, or any service performed without prior financial arrangements, must be paid for with cash, check or credit card at the time services are performed.

Initials: _________

It is our office policy that you call or text the front desk to cancel or re-schedule an appointment at least 30 minutes prior to the time of your appointment. Otherwise, a $25 fee will be charged. This policy allows others that need these times to not be turned away from receiving care. This fee will be charged directly to the patient/guarantor, not to the patient's insurance. Additionally, all No Show Fees MUST be paid prior to the next appointment. It is also our policy that a missed appointment is made up within 7 days. This is to maximize your goals of getting pain free, having optimal function, and getting the best structural correction possible in the most efficient and effective manner. If you are leaving on vacation or a business trip, let us know so that you can 'make up' those days before and/or after your trip. We want you to feel your very best at all times!

Initials: _________

The patient is ultimately responsible for payment in full for their account, not the insurance company. We do, however, submit chiropractic insurance claims as a courtesy to our patients. We can only make estimates regarding you insurance company's reimbursement to our office based on the information provided by you as well as the insurance company. This office uses our usual and customary fees. The undersigned hereby consents to pay any and all balance on their account for chiropractic services rendered as agreed upon in the individual's care plan recommendations.

Initials: _________

If it is necessary for our office to turn your account over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees or discounts.

Initials: _________

I grant my permission to Dr. Miller or staff members of Rock Chiropractic to telephone me at home or at my work to discuss matters related to this form.

Initials: _________

I have read the above terms and conditions of treatment. I understand and agree to the content of this form.

____

Patient Signature

____

Date

Rock Chiropractic

Informed Consent

Where miracles can happen

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternative.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____________________________________ ____________________________________ _______________

Printed Name Signature Date

Consent to evaluate and adjust a minor child:

I, ____________________________, being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual cycle: ____/____/____

____ _____________________

Signature Date

Phone Calls:

I authorize Rock Chiropractic staff members to call the following telephone numbers and leave a message regarding my care and/or my appointment times. (Please fill in all that you give permission for.)

Home #: ___________________________________ Cell #: ___________________________________

Work #: ___________________________________ Spouse/Partner #: __________________________

Parent #: ___________________________________

____ _____________________

Signature Date