

Be Well Chiropractic Center

Name _____

Address _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Home (____) _____ Work(____) _____

Email _____ Social Security Number _____

Date of Birth _____ Marital Status _____

Referred by _____

Occupation _____ Employed by _____

Does Be Well Chiropractic have a copy of your insurance card and drivers license _____

If patient is a minor:

Name of parent _____

Address of parent _____

City _____ State _____ Zip _____

Have you had previous Chiropractic care? _____ Date of care _____

What is your primary complaint? _____

Duration of condition? _____

Have you previously had this same problem? _____

What treatment have you had for it? _____

What are you doing for your problem now? _____

Has that been effective? _____

Are you seeing another doctor for any reason, including pregnancy? _____

Are you currently taking any medication? _____ (Please list on back of sheet)

Have you ever had any serious falls, accidents, strains, etc? _____

(List on back of sheet if necessary)

To the best of my knowledge, I am not pregnant at this time _____ (please initial)

I certify that the given information is true and complete to the best of my knowledge.

Patient's signature _____ Date _____

Parent signature if patient is a minor

**CONSENT FOR PURPOSE OF TREATMENT,
PAYMENT AND HEALTHCARE OPERATIONS**

I acknowledge that Bell Well Chiropractic Center’s “Notice of Privacy Practices” is available for my viewing and provided on request by the administrative desk of this practice.

I understand I have a right to review the privacy policies prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment and payment of my bills or in the performance of health care operations of Be Well Chiropractic Center. It also describes my rights and Be Well Chiropractic Center’s duties with respect to my protected health information.

Be Well Chiropractic Center reserves the right to change the privacy practices that are described in the “Notice of Privacy Practices”. I may obtain a copy of the revised policies by the calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Description of Personal Representative’s Authority

Authorization and Assignment

(Please Initial)_____ **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 for reimbursement of charges incurred by me as a result of professional services rendered by you and I hereby release you of any consequences thereof.

(Please Initial)_____ **Assignment of Payment:** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any monies is due him on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference, if any, between the total amount of his charges and the amount paid to him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

(Please Initial)_____ **Medicare Assignment:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

(Please Initial)_____ **Consent to care for minor child:** I hereby authorize the doctor listed below and whomever he may delegate to administer Chiropractic care as he deems necessary to my child,

_____.

Acknowledgement and Understanding:

I hereby acknowledge that I understand that chiropractic treatment is not disease oriented in treatment methods or diagnosis but rather is aimed enhancing the body's ability to reach its' maximum potential for healing. As with any healing art there are no guarantees of cure and always limited risks involved with care.

I further acknowledge that I am receiving (or about to receive) health care services from **Be Well Chiropractic Center** and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

- A. T
hat there is no insurance company obligated to pay for services, of 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. I
f 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: then payment of services rendered by **Dr. Jason Ellis** 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.

Patient Signature _____ Date _____

Witness _____ Date _____