PATIENT INFORMATION

(PLEASE PRINT)

NAME_____ DATE_____

ADDRESS_____CITY_____ STATE_____ZIP_____

PHONE_____SOC. SEC. NO._____ DATE OF BIRTH_____

EMAIL_____ (We provide a free informational email about health and wellness.)

OCCUPATION_____EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

MARITAL STATUS_____SEX_____AGE_____

SPOUSES'S NAME_____

EMPLOYER_____

IS THE PATIENT A MINOR? YES_____ NO_____

PARENT'S NAME_____

EMPLOYER_____ SOC. SEC. NO._____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

**WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY NOTIFICATION

NAME _____

RELATIONSHIP_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the following and if you have any questions please feel free to ask one of our staff members.

Continue to next page

INFORMED CONSENT:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Moore Chiropractic & Wellness**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women ONLY:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave voicemails regarding your personal healthcare information? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Dear Patient,

It has been our experience that our patients have a complete understanding as to our office policy and fees. We offer several methods of payment to aid you in obtaining the best chiropractic care. When making a health care decision, it is important to remember that you, the patient, are ultimately responsible for any services rendered.

CASH: Each visit can be paid by check, cash or credit card. We accept Visa, MasterCard, and Discover. Fees are currently $40.00 per visit, or you can pre-pay $130.00 for four visits. There is a family rate of $60.00, for families of four or less. There is a family rate of $110.00 for families of five or more. We do require all who will be included in the discount to be living in the same household. Any children out of school or any married children must contribute to a separate fee of $40.00 which is the discounted rate.

INSURANCE: Many insurance carriers cover chiropractic care. You must present your card at the time of your visit. You will be responsible for any uncovered services. Normally, uncovered expenses include: *deductible, co-insurance and any other excluded amounts or services*. This office does not promise that an insurance company will pay for the usual and customary charges, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement. If you do not present your insurance card at the time of your visit, please refer to the **CASH** portion of this letter.

WORKER'S COMPENSATION INJURIES: If you were hurt on the job, most employers carry insurance to cover the treatment of your injury. We must receive verification *prior* to your examination and treatment for this to be billed directly. There is no out-of-pocket expense to the patient of job-related injury claims. Any payments made by the patient prior to verification are reimbursed after our office receives payment from the insurance carrier. If the claim is denied, payment is the responsibility of the patient.

AUTO ACCIDENTS: If you are involved in an auto accident or related injury, we must receive the insurance company, claim number and contact person for your accident before you will be permitted to see the doctor.

MEDICARE: We will bill Medicare and your secondary insurance for you. Medicare will pay 80% of all office visits that are medically necessary after you have met your deductible. Your responsibility is 20% if you do not have a secondary insurance. Charges for any therapy in this office will be your responsibility.

OHIO MEDICAID: Currently, Medicaid will cover 30 visits per year for patients under the age of 21 and 15 for those 21 and over. Any visits over this amount are the patient's responsibility. Patient must present their card of eligibility at the time of their appointment. If you do not have a Medicaid card at the time of your visit, you will not be permitted to see the doctor.

We ask that you sign this form as acknowledgment that our policy was explained to you, that you accept full financial responsibility. Failure to comply with this agreement may result in termination of professional care.

Patient Signature: _____ Date: _____