MOREA
Chiropractic Wellness Center
(231) 865-7474 | MoreaChiro.com

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Today's Date (MM/DD/YYYY)

How were you referred?

Gender
◯ Male ◯ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (Or Initial)

Birth Date (MM/DD/YYYY)

Address

Marital Status
◯ Single ◯ Married
◯ Divorced
◯ Widowed ◯ Separated

City

State

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Spouse's Birth Date

E-Mail Address

Child's Name & Age

Emergency Contact

Phone

Child's Name & Age

Your Occupation

Your Employer

Child's Name & Age

Primary Physician

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):____**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **I may request a copy of the Financial Policy at any time.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: ____

CONFIDENTIAL HEALTH INFORMATION

INFORMED CONSENT TO TREAT

The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as ”Spinal Manipulation” or Spinal Adjustment” As the joints in your spine are moved, you may experience a “pop” as part of the process. There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. **If you have already experienced a stroke, an approval to receive chiropractic care must be signed by your primary care physician. ** The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when we take your clinical history.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

HIPPA PRIVACY PRACTICES

I acknowledge that Morea Chiropractic Wellness Center, PLC “Notice of Privacy Practices” has been made available to me. I understand I have the right to review Morea Chiropractic Wellness Center's Notice of Private Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at Morea Chiropractic Wellness Center. The Notice of Privacy Practice is also posted on our website at www.moreachiro.com. It is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Morea Chiropractic Wellness Center, duties with respect to my protected health information. Morea Chiropractic Wellness Center, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Please list below the names of person(s) authorized to gain access to patient account information:

_____

_____

ACKNOWLEDGMENT OF UNDERSTANDING

By signing below, I acknowledge that I have been provided a copy of the Morea Chiropractic Wellness Center, Policies and Payment Policy. I have also been notified of the HIPAA Policy and Privacy Practices utilized in this office. Copies are posted on our website at www.moreachiro.com it is also provided upon request at the main administration desk. I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, copays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as agency fees, court costs, and attorney fees. Upon placement of your delinquent account with a third party collector (eg. collection agency or collection law firm), you will be responsible for and your account will be assessed, a collection fee in the amount of 33.33% of the then outstanding balance. My signature also authorizes the payment be made directly to Morea Chiropractic Wellness Center for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare. Morea Chiropractic Wellness Center reserves the right to transfer account credits within a family to settle balances due. I understand and agree that Morea Chiropractic Wellness Center has the right to refuse to accept me at any time before treatment begins. (A consultation and the conducting of a physical evaluation are not considered treatment.) I authorize the staff of Morea Chiropractic Wellness Center to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature of Patient/Patient Representation (parent, guardian) ***Date***

_____ _____

Signature of Patient/Patient Representative **Date**

Acknowledgement of Special Promotion

I acknowledge that the discount with (coupon / referral card / other: _____) is a special promotion at Morea Chiropractic Wellness Center designed to allow me to receive care only at Morea Chiropractic Wellness Center. As such, I understand that upon my request for records, either for my own person use or any other doctor, hospital, person or institution, I will be charged the full usual or customary fees for the services I originally received at a discounted rate. I expect to receive no further notice of this policy.

Name (print) _____ Date _____

Signature _____ Witness _____