# WELCOME TO ZARZANA CHIROPRACTIC

**Patient Information** (Pease Print) **Please complete all sections**
**If not applicable please indicate with "NA".**

Name_____Social Security #_____
First Middle Initial Last

Address_____City_____State_____Zip_____

Sex: [] Female [] Male Date of Birth_____ e-mail_____

[] Single [] Married [] Domestic Partner [] Widowed [] Minor Height:_____Weight:_____

Who may we thank for referring you today?_____

Home Phone ( ) _____Cell Phone ( )_____

Work ( ) _____ Do you prefer to be contacted at: Home[] Work [] Cell []

Patient Employer Information _____Occupation_____

Address_____City_____State_____Zip_____

**Emergency Information**

[] Spouse [] Domestic Partner [] Parents [] Other_____

Name_____

Work ( )_____Cell ( )_____

**Responsible Party**

Responsible person for this account: _____Date of Birth: _____

Relationship [ ] Self [] Spouse [] Domestic Partner [] Child

Address _____City _____State _____Zip_____

Home Phone ( ) _____Cell Phone ( )_____Work ( ) _____

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**Insurance Information**

Name of Insured_____Date of birth_____

Relationship to patient_____Social Security #_____

Name of Insured_____Date of birth_____

Insurance _____Subscriber ID_____Group #_____

Employer Name_____

Address_____City _____State_____Zip_____

**Do you have additional insurance? [] Yes [] No If yes, please complete the following**

Name of Insured_____Date of birth_____

Relationship to patient_____Social Security #_____

Name of Insured_____Date of birth_____

Insurance _____Subscriber ID_____Group #_____

Employer Name_____

Address_____City _____State_____Zip_____

**Accident Information**

Is this condition due to an accident? [] Yes [] No Date of Accident_____

Type of accident [] Auto [] Work [] Home [] Slip and fall [] Other_____

Attorney Name_____ Phone Number ( ) _____

Are you right or left handed? [ ] Right [ ] Left

**What are your current complaints: Please circle those that apply**

Back Pain Neck Pain Headaches Shoulder Pain Arm or Wrist Pain Leg, Knee or Ankle Pain

Other: Please Explain _____

Signature:
_____Date:_____

# FINANCIAL AGREEMENT HEALTH INSURANCE

Patient Name:_____

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

**Explanation of Insurance Coverage:**
Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

**Payment Arrangements**
We require that you pay you set co- payment or co-insurance at the time of each visit. Your full portion of the bill is expected to be paid when payment is received from your insurance carrier. Any unpaid balances within 90 days of notification of the amount due will result in collection proceeding unless prior arrangements are made. For patients that do not have insurance payment is due at the time services are rendered, we do not bill for cash visits.

**Assignment of Benefits**
By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. All patients with insurance are required to pay for all non-covered services.

**Release of Information**
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

**Cancelation Policy**
I have been notified that Zarzana Chiropractic, Inc. requires a 24 hour cancelation of all appointments. All canceled and re-scheduled appointments without a 24 hour notice will be charged the following:

- Chiropractic Appointments $20.00
- Massage Therapy will be charged the full rate
- Acupuncture will be charged the full rate
- Personal Training appointments will be charged the full rate

**Voluntary Termination of Care**
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

**I have read and agree to the above.**

_____ _____

**Signature** **Date**

# Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Witness Signature

_____

Date

Zarzana Chiropractic, Inc.
1777 Bellflower Blvd. suite #109
Long Beach, CA 90815

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____
Patient Signature Date

**Certification and Assignment:**
To the best of my knowledge, my information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with_____
Name of Ins. Company(ies)

And assign directly to Dr. Zarzana all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Zarzana may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is complete.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please Print Name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient