HAMBY CHIROPRACTIC & WELLNESS

# Terms of Acceptance

**Patient Name:** _____ **Date:** _____/_____/_____

## 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 at Hamby Chiropractic & Wellness, Ltd.,** I am authorizing them to proceed with any treatment that the doctor deems necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

## Authorization of Care

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments, modalities, and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this office. I also understand that if I do not follow the doctor's specific recommendations that I will not receive the full benefit from the recommended care programs.

## Consent to Evaluate and Treat a Minor:

I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

## X-Ray Permission:

I, **() give** or **() do not** give permission to x-rays for diagnostic interpretation.

## Missed Appointments:

We are committed to providing each patient with exceptional care. When a patient cancels without giving adequate notice, they prevent another patient from receiving the same exceptional care. **Please contact our office at (912) 826-4444 within 24 hours prior to your scheduled appointment. If prior notification is not given, a $30 fee may be charged.**

**I have read and fully understand all the above statements.**

**Signature of Patient/Legal Guardian**: _____ **Date:** ____/____/____

## Acknowledgement

We are very concerned with protecting the privacy of your health information. There are several circumstances in which we may have to use or disclose your health information. We may disclose your health information to another healthcare provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of services. I understand I will be given a complete copy of the notice of privacy practices (HIPAA) upon request.

## Communications:

I understand that disclosure may be made to family/friends regarding my health or as needed for payment of health care services. That information will only be disclosed relevant to current treatment. I give my permission for my health care information to be disclosed to the following people:

| Family Member/Friend | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |

## Legal Assignment of Insurance Benefits and Release of Medical Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to **Hamby Chiropractic & Wellness, Ltd**. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such provider and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between the carrier and myself. I understand that insurance carriers may deny my claims and that I am ultimately responsible for all unpaid balances.

This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original.

**I have read and fully understand all the above statements.**

**Signature Patient/Legal Guardian**: _____ **Date:** ____/____/____