

PATIENT INFORMATION

E-Mail: _____
Last Name: _____ First Name: _____ MI _____
Address: _____
City: _____ State: _____ Zip _____

IDENTIFICATION

Social Security#: _____ Sex: M _____ F _____
Date of Birth: _____ Marital Status: S M D W
Family Physician: _____

PATIENT EMPLOYMENT

Employer: _____
Occupation: _____
Phone: _____

Who Referred You? _____

INJURY INFORMATION

What complaint or symptom prompted your visit to the office today?

When did you first notice the problem? _____

Was it caused by: Auto Accident _____ On the job injury _____ Unsure _____

What makes it worse? _____

What makes it better? _____

Have you been treated for this condition? If so, by whom? (doctor, physical therapist, etc) _____

Telephone Numbers

Home Phone: _____
Work Phone: _____
Cell Phone: _____

SPOUSE/PARENT IDENTIFICATION

Name _____
SS# _____
Date of Birth _____
Employer _____
Work# _____

PRIMARY INSURANCE

Insurance Co _____

SECONDARY INSURANCE

Insurance Co _____

PLEASE PROVIDE COPY OF YOUR CARD

CONSENT TO TREAT MINORS

I, _____ acting as parent or legal uardian, hereby grant permission and authorize his/her physician to treat _____ without the benefit of my presence in the office.

The undersigned patient assigns the treating physician the following rights, power and authority:

I request that payment of authorized Medicare benefits or other third party insurance benefits be made either to me or my behalf to Natural State Healing Arts, Inc., for services furnished me by that provider. I authorize any holder of medical information about me to release to Natural State Healing Arts, Inc. or his agents, any information needed to determine these benefits payable for related services. I authorize the release of any and all past and present medical records to Natural State Healing Arts, Inc.. You are assigned to the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment, and to prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits of any kind to me/us for treatment rendered by my physician, you are hereby tendered demand to pay in full the bill for services rendered by him following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy. If patient's services for injuries are the result of the negligence of any third party, then patient or responsible party grants a lien against any recovery from such third party (s) to the extent of bills for service, in favor of my physician. Patient waives the right to claim statue of limitations regarding claims for services rendered or rendered by Natural State Healing Arts, Inc. in addition to reasonable costs of collection, including attorney's fees, court costs and interest charges incurred. I understand Medicare may not pay for every treatment received by Natural State Healing Arts, Inc., as Medicare requires treatment to be medically necessary to their reviewers. If Medicare does not pay for said treatment, I understand I will be responsible for payment and that Medicare may not pay for X-rays.

PLEASE INITIAL: _____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other procedures including various modes of acupuncture, physical therapy and, if necessary, diagnostic X-rays, on me by Natural State Healing Arts, Inc. and anyone working in this clinic authorized by Natural State Healing Arts, Inc.. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains/sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time based upon the facts then known, is in my best interests. I have read the above consent. I have also had the opportunity to ask questions about its content, and by initialing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE: _____

Patient Privacy

The privacy law, Health Insurance Portability & Accountability (HIPPA), protects your individually identifiable health information (protected health information). The privacy law requires you to sign an authorization (or agreement) in order for your healthcare provider to request or disclose your protected health information. By signing this form you are giving us authorization to send the Natural State Healing Arts, Inc. this information. You are also giving the Natural State Healing Arts, Inc. authorization to re-disclose your information to the party responsible for the payment of your services, the Natural State Healing Arts, Inc. legal counsel, and state or federal agencies that may be asked to intercede on your behalf. You may restrict the individuals or organizations to whom your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by the person who receives the information and may no longer be protected by federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we may send to the Natural State Healing Arts, Inc. at any time. This notice is effective as of today's date (below). This authorization will expire seven years after the date on which you last received services from us. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization

PLEASE INITIAL: _____

Insurance and Financial Agreement

The undersigned patient assigns the treating physician the following rights, power and authority:

I understand that I am directly and fully responsible to the clinic for all medical bills submitted by them for services rendered to me and that this judgement is made solely for the clinic's additional protection and in consideration of their awaiting payment. I further understand that such a payment is not contingent on any settlement, award, judgement, or verdict. PLEASE INITIAL: _____

I request that payment of authorized Medicare benefits or other third party insurance benefits be made either to me or my behalf to Natural State Healing Arts, Inc., for services furnished me by that provider. I authorize any holder of medical information about me to release to Natural State Healing Arts, Inc. or its agents, any information needed to determine these benefits payable for related services. I authorize the release of any and all past and present medical records to Natural State Healing Arts, Inc.. You are assigned to the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment, and to prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits of any kind to me/us for treatment rendered by my physician, you are hereby tendered demand to pay in full the bill for services rendered by him following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

PLEASE INITIAL: _____

If patient's services for injuries are the result of the negligence of any third party, then patient or responsible party grants a lien against any recovery from such third party (s) to the extent of bills for service, in favor of my physician. Patient waives the right to claim statute of limitations regarding claims for services rendered or rendered by Natural State Healing Arts, Inc. in addition to reasonable costs of collection, including attorney's fees, court costs and interest charges incurred. If any PIP or Med Pay insurance policy through which the undersigned patient is entitled to benefits prohibits direct payment to health care providers, then both the undersigned patient and the Provider, hereby instruct and direct that any and all checks, drafts or other negotiable instruments are issued payable to both the undersigned patient and the Provider in such a manner as to require the endorsement of the provider to negotiate or cash said checks, drafts or other negotiable instrument. I also grant limited power of attorney to Provider to endorse/sign my name on any and all checks, drafts or other negotiable instruments for payment to the Provider. If any portion of any charge for these services is either reduced or denied in whole or in part, both the Provider and the undersigned patient demand, and the insurance carrier is hereby instructed accordingly, that the insurance carrier place funds equal to the amount of the reduced or denied charges into escrow or otherwise preserve the disputed benefits at issue until such time as all escrowed funds are paid to Provider, the dispute giving the rise to the escrow is resolved or Provider instructs the insurance company, in writing, that Provider is no longer making any claim to escrowed funds. PLEASE INITIAL: _____

If any language within the agreement is determined to be invalid or otherwise unenforceable, that language shall be deemed void and the remainder of this agreement shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original. If Provider is providing medical care related to the accident, then these bills shall be paid to the full extent of the benefits available under my policy of insurance.

PLEASE INITIAL: _____

I understand Medicare may not pay for every treatment received by Natural State Healing Arts, Inc., as Medicare requires treatment to be medically necessary to their reviewers. If Medicare does not pay for said treatment, I understand I will be responsible for payment and that Medicare may not pay for X-rays.

PLEASE INITIAL: _____

Patient Name

Signature

Printed Date