INSURANCE INFORMATION

Name of party responsible for this account _____

Subscriber's Name _____D.O.B_____SS#_____
Relationship to Patient _____
Insurance Company _____
ID# /Group#_____/_____

Is patient covered by additional insurance? ___ YES ___ NO
Subscriber's Name _____D.O.B._____SS#_____
Relationship to Patient _____
Insurance Company _____
ID #/Group # _____/_____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with the following insurance company(ies)_____ and assign directly to Optimum Health Chiropractic, LLC 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.
Optimum Health Chiropractic, LLC may use my healthcare 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 payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

Please Print Name of Patient, Parent, Guardian or Personal Representative:

_____

Signature of Patient, Parent, Guardian or Personal Representative:

_____

Date: _____Relationship to Patient: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

Doctor-Patient Relationship in Chiropractic Care

How does Chiropractic care work?

Chiropractic healthcare seeks to restore health through natural, conservative means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes and physical and spinal conditions.

A doctor of chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When a VSC is found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. Due to the complexities of nature, no doctor can promise you specific results, results depend on the inherent recuperative powers of the body and the individual receiving the care.

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not internal specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern about the nature of their total condition.

Patient Consent

I hereby request and consent to the performance of chiropractic procedures including various modes of physio therapy, diagnostic x-rays and any supportive therapies on me (or the patient named below for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by the office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purposes of chiropractic adjustments and procedures.

I understand that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I also understand that in the practice of chiropractic there are some risks of treatment including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I rely on the doctor to exercise judgment during the course of procedure which, based upon the facts known, is in my best interests.

Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment. I further understand that there are treatment options available for my condition other than chiropractic procedures.

I have read, or have had read to me, the above consent and have had the opportunity to ask questions about its content. By signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient or Legal Guardian: _____

Guardian Relationship to Patient: _____

Signature of Patient or Guardian: _____

Date: _____

Name of Practice: Optimum Health Chiropractic

Doctor of Chiropractic Name: _____

Signature of Doctor: _____

Date: _____

Protected Health Information Consent Form

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operation, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to these restrictions
3. A patient's written consent need only be obtained one time for all subsequent care given the patient at this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been made.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my PHI will be used and I agree to these policies and procedures.

Signature_____ Date _____

2517 Hwy. 35; Bld. L; Suite 102
Manasquan, NJ 08736
732-528-9090 office
732-528-9060 fax

X-RAY POLICY

When x-rays are taken in our office at any given time, they are a part of your permanent record. We are legally obligated to keep them for seven years. _____
(Initial)

If you should ever require a copy of your x-rays, we will gladly email them to you or your physician. _____
(Initial)

We will not release the x-ray films to anyone. If you should require the actual films, we will send them out to be copied. It may take up to three weeks to receive the replicated films. You will be financially responsible for all replication fees. _____
(Initial)

I, _____, fully understand the above statements.
(Patient name)

Signature: _____ Date: _____