Comprehensive Chiropractic Center

Patient Information

Date: Cell # ( )

Patient Name: Home # ( )

Address: Email Address

City: State Zip:

Age: Date of Birth Sex: Soc. Sec #:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Employer: Work # ( ) Ext:

Have you previously had Chiropractic Care: ☐ Yes ☐ No

Have you ever been in an auto accident? ☐ Yes ☐ No Date of accident:

Reason for Visit:

How long have you had this condition?

Do activities aggravate this condition?

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Occasional

Have you seen other doctors for this condition?

Last physical exam by a physician:

List of current medications:

List of previous surgeries:

Emergency contact: Phone # ( )

Patient Signature (X) Date:

SIGN HERE

10123 West Oakland Park Blvd • Sunrise, FL. 33351 • (954) 748-7455 FAX (954) 748-5517

Comprehensive Chiropractic Center

Insurance Information and Consent Form

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance:	Name of Insurance:
Insured's Name:	Insured's Name:
Insured: ☐ Male ☐ Female	Insured: ☐ Male ☐ Female
Insured's Date of Birth:	Insured's Date of Birth:
Insured's Social Security # :	Insured's Social Security # :
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ☐Child ☐Other	Relationship to Insured: ☐Self ☐Spouse
Patient ID #:	Patient ID#:
Group #:	Group #:

CHARGES FOR SERVICES RENDERED

All charges for office services are due at the time of my visit to Comprehensive Chiropractic Center (The Practice). If an insurance claim is filed by The Practice, I request that payment of all benefits be made on my behalf to The Practice.

FINANCIAL RESPONSIBILITY

We are pleased to submit your claims for treatment to your insurance carrier, however I understand that I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

SHARING/DISCLOSING HEALTH INFORMATION

I authorize The Practice to share, disclose, or otherwise release medical information about me to my insurance company or any other authorized entity involved in my healthcare in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or healthcare operations). I further authorize The Practice to gain access to medical records with information relevant to my treatment form any and all other healthcare providers, including but not limited to hospitals, laboratories, physicians, and others.

TREATMENT

I further authorize and consent Dr. Rick Buchalter, his assistants and other Practice professional staff providing medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

CANCELLATION

I agree that I will provide at least twenty-four (24) hours notice to The Practice when canceling an appointment and understand that a failure to provide such notice may result in a prolonged waiting period and/or cancellation fee.

SIGN HERE

Patient Signature (X) _____ Date: _____

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Notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Comprehensive Chiropractic Center. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. We encourage you to read it in full.

Out Notice of Privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us the above address.

I acknowledge receipt of the notice of privacy practices of Comprehensive Chiropractic Center.

SIGN HERE

Signature: _____ Date: _____

(Patient/Parent/Legal guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why acknowledgement was not obtained.

Signature of provider representative: _____ Date: _____

An acknowledgement was not obtained because:

☐ Patient refused to sign

☐ Patient was unable to sign initial because:

_____

☐ There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

☐ Other

Reason(s) _____

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