Last Name: _____ First Name: _____ M.I. ____
DOB: _____ Cell: _____
Email: _____ Newsletter? Y or N
Address: _____
City: _____ State: _____ Zip: _____
How did you hear about Family Focus Chiropractic? _____
Would you like to receive reminders for future appointments? Y or N
If yes, Please circle one. Text or Email

Billing Policy

It is important that you understand that, as your health care provider our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. Please try to remember that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. Our office cannot be responsible for monitoring each contract exclusion or limitation.
3. There are some services done in this clinic that are not covered by most insurance companies, including Medica, Health Partners, and Medicare. They include: Nutrition Consultations, many blood tests (including the vitamin D test), Functional Medicine, and wellness or maintenance chiropractic care.
4. We will be happy to contact your insurance company to determine your benefits, however, any information our office gives you is an estimate based on the information available to us. Any changes in your coverage should be reported to Family Focus Chiropractic, LLC immediately.
5. Accounts that have patient balances due and there is no payment made for 60 days may be charged a $15 rebilling fee every month. It is our policy that any balances over 90 days may be turned over to a collection agency. You will also be responsible for any fees in the collection process. These overdue accounts would be reported to the credit bureau.
6. I have read and agree to the above_____

Notice of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

1. Disclosures of your protected health information without authorization are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. We will also send daily notes/records with medical billing, as necessary, to insure proper processing. We will disclose information for the purposes of treatment and practice operations as well. You may request restrictions on disclosures.
2. YOU AUTHORIZE FAMILY FOCUS CHIROPRACTIC LLC TO DISCUSS YOUR TREATMENT AND ACCOUNT WITH YOUR SPOUCE OR ANOTHER FAMILY MEMBER.
3. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
4. You may inspect and receive copies of your records within seven (7) days of a request. There may be a reasonable cost-based fee for photocopying, postage and preparation. Electronic copies are available within 3 business days.
5. You may request changes to your records. Our practice has the right to accept or deny the request.
6. We maintain a history of protected health information disclosures that is accessible to you.
7. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
8. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations with the Office Manager.

I have read and agree to the above_____

FAMILY FOCUS CHIROPRACTIC, LLC WILL BILL YOUR INSURANCE

I authorize payment of medical benefits to the physicians at Family Focus Chiropractic, LLC for services supplied to me. I also authorize the release of any medical information, or information necessary to process my claims.

_____ _____ _____
Print Patient Name Signature Date

Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

To the nature of the chiropractic adjustment.

The primary treatment used by Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures (unless otherwise noted on the lines below): spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, EMS, and radiographic studies.

_____

_____

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such option and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize the Doctor of Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other Doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Family Focus Chiropractic and/or it's staff and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Parent/Guardian's Name: _____ (if for minor)

Signature: _____ (signature of Parent or Guardian if a minor, otherwise for self)