Ad Waiver

Welcome to Refine Chiropractic -

We look forward to helping you. Since you responded to our ad, it's important that you clearly understand what is covered by the New Patient Promotion.

The New Patient Promo includes the following:

- ☑ **1-on-1 Consultation**
- ☑ **Spinal and Nervous System Exam**
- ☑ **Comprehensive Nervous System Scans**
- ☑ **Postural Analysis**
- ☑ **Neck & Lower Back X-Ray**
- ☑ **Range of Motion Exam**
- ☑ **Detailed Doctor's Report of Findings**
- ☑ **AND (Optional) First Adjustment all for just $29 ($300 value)**

There are no exclusions or conditions for this ad. We encourage your questions and we will do our best to strive and make your visit here helpful.

Welcome to Refine Chiropractic - .

Sign Here_____ **Date:**_____

Refine CHIROPRACTIC

Acknowledgement of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practices has been made available to me. I also understand that this Notice is available by request.

Name of Patient or Legal Representative **Date**

Signature of Patient or Legal Representative **Date**

Facility Use Only

☐ **Patient has been provided Acknowledgement of Notice of Privacy Practices and has refused to sign.**

Refine
CHIROPRACTIC

Authorized Staff Signature **Date**

Refine CHIROPRACTIC

Informed Consent for Chiropractic Care

Welcome to our chiropractic office. We prioritize your active involvement in decisions regarding your healthcare. As a new patient, it's essential for you to understand the following points about chiropractic care before commencing treatment:

You play a pivotal role in your healthcare decisions. Our goal is to provide you with information to support your informed choices. This process, referred to as "informed consent," entails understanding and agreeing to the care we recommend, including the benefits and risks associated, available alternatives, and the potential effects on your health if you choose to decline the recommended care.

We may perform diagnostic or examination procedures if needed. Please be aware that while these tests are conducted carefully, they might cause discomfort. Chiropractic care primarily involves what's known as a chiropractic adjustment. This process includes repositioning anatomical structures, such as vertebrae, using hands or specialized instruments. Additional supportive procedures or recommendations might accompany the adjustment to restore normal joint motion, reduce inflammation, alleviate pain, and enhance your overall well-being.

The potential benefits of a chiropractic adjustment include restoring normal joint motion, reducing inflammation, alleviating joint pain, and improving neurological functioning. However, it's crucial to understand that, as with any healthcare approach, results cannot be guaranteed, and there is no promise of a cure. Risks associated with chiropractic care may include but are not limited to muscle spasms, temporary worsening of symptoms, and possible injuries like fractures, strokes, strains, and sprains.

A rare but serious condition, arterial dissection, may lead to a stroke. Scientific evidence supports that a chiropractic adjustment does not cause dissection in a normal, healthy artery. Patients who experience this condition may present symptoms of neck pain and headaches. It's important to note that the reported association between chiropractic visits and stroke is exceedingly rare, estimated to occur infrequently. Alternate treatment options exist, and you have the right to explore these alternatives.

By signing below, you acknowledge that you've read or had this document read to you, understood its content, and had an opportunity to ask questions. You agree with the current or future recommendations for chiropractic care deemed appropriate for your circumstances. This consent covers the entire course of care from all providers in this office for your present and any future conditions for which you seek chiropractic care.

New Patient Information

Patient Name:_____

Patient Signature:_____ **Date:**_____

Parent or Guardian (if applicable):_____

Refine CHIROPRACTIC

Witness Signature:_____ **Date:**_____

Welcome to Refine Chiropractic

Financial Agreement

At ChiroSource, we aim to provide you with exceptional care. Please take a moment to review and acknowledge our financial agreement. Please be aware that insurance is a method for reimbursing the patient for the fees charged by the doctor and is Not A Substitute For Payment. Certain insurance companies pay fixed amounts for specific procedures, while others pay a percentage of the charge. It is the patient's responsibility to cover any deductible, co-insurance, or any remaining balance not paid by the insurance.

TO MANAGE OUTSTANDING BALANCES EFFECTIVELY, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES AT THE TIME OF SERVICE.

In the event this account is assigned to an attorney or outside agency for collection or legal action, ChiroSource reserves the right to claim reasonable attorney's fees and collection costs.

I hereby authorize the release of any necessary information to determine liability for payment and to obtain reimbursement for any claim.

Patient's/Guardian's Name **Insured Signature**

Insurance Company Name **Date**

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the expected medical expenses, I, the undersigned individual, currently possess insurance and/or employee healthcare benefits coverage related to the aforementioned doctor and clinic. By virtue of this, I hereby assign and transfer directly to ChiroSource any medical benefits and insurance reimbursements, if available, otherwise payable to me for the services rendered by the doctor and clinic. I comprehend that I am wholly responsible for all charges, irrespective of any applicable insurance or benefit payments. In addition, I grant authorization for any plan administrator, fiduciary, insurer, or my attorney to release any necessary plan documents, insurance policies, or settlement information to the doctor and clinic upon their written request. This is to

facilitate the claiming of medical benefits, reimbursement, or any applicable remedies. I further authorize the use of my signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the named doctor and clinic the full extent permissible by law and under any applicable insurance policies or employee healthcare plans, any claims, actions, or rights I may hold to insurance and/or employee healthcare benefits coverage. This includes any such rights concerning medical expenses incurred due to the medical services received from the aforementioned doctor and clinic. I grant permission, to the extent permitted by law, for the claiming of medical benefits, insurance reimbursements, and any applicable remedies. Moreover, I agree to cooperate with the doctor and clinic in any reasonable attempts by them to pursue such claims, actions, or rights against my insurers and/or employee healthcare plan. This cooperation includes, if necessary, legal action brought by the doctor and clinic against the insurers and/or employee healthcare plan in my name, at the doctor and clinic's expenses.

This assignment remains valid until I formally revoke it in writing. A photocopy of this assignment is deemed valid as the original. I confirm that I have read and fully understand this agreement.

_____

Patient's/Guardian's Signature **Date**

PATIENT SMS CONSENT FORM

Name _____ **Date of Birth**_____.

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice. ChiroSource - Madison is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS.

Acknowledgements and Consent

I acknowledge and agree that, in the course of providing health care services to me, ChiroSource - Madison may need to use and disclose my personal information (including any health information) as set out in this form. I wish to receive communications (as described above) and I hereby specifically consent to the use of my personal information (including any health information) by this general practice to assess the types of health awareness communication it sends me and specifically consent to receipt of such health awareness communications.

My preferred contact method for all communication is: SMS ☐ Email ☐ Letter ☐

Please provide your most current telephone contact details:_____

I acknowledge that the ChiroSource - Madison will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by

more than one patient, I understand and consent that all SMS and phone communications will be directed to that number. Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Parent / Guardian Name (if patient is under 18yrs):_____**Date:**_____.

Patient Signature_____ **Date:**_____

In keeping with our obligations under HIPAA Privacy Act, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information). Please refer to our privacy policy or privacy statement for more information on the management of personal information (including health information) by ChiroSource - Madison . In addition to other communications we may send you from time to time, we may send you the following types of communications: 1. appointment reminders – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment; 2. clinical reminders - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due; 3. clinical communications - communications to you about your clinical care at the practice such as clinical messages from the medical practitioner; and 4. health awareness – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications.

New Patient Entrance Application

We're thrilled to have you with us at ChiroSource Madison. To ensure we evaluate your health effectively, kindly complete the following personal information. Notify our front desk team member if you require any assistance. Thank you for choosing ChiroSource!

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____Gender:____M ____F

Address:_____

City:_____ State: _____ Zip Code:_____ SSN # _____-____-_____ DL#_____

Home Phone: _____ Cell Phone_____ Work Phone_____

Refine CHIROPRACTIC

Birthdate:_____ Age:_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other _____

Spouse Name:_____ Birthday:_____

Children: Names and Ages:_____

Employer Information

Patient Employer/School Name _____ Employer/School Phone _____

Occupation_____ How Long? _____

Insurance Information

Name on Insurance Card:_____ Relationship to Patient:_____

Insurance Company_____ID#_____ Group#_____

IN CASE OF EMERGENCY, CONTACT INFO

In Case of Emergency, Whom Should We Contact?_____ Relationship _____

Home Phone _____Cell Phone _____

Family Physician: _____

May we send your Family Physician updates on your progress? _____ Yes _____No