Date of Apt: ____/____/____ at _____ am/pm | Doctor _____ | Acct: _____ | Insight □

Patient Information

Name: _____ Cell Phone:_____ E-mail: _____

Date of Birth: ____ / ____ / _____ Age: _____ Social Security Number _____-_____-____

Address: _____ City:_____ St: ____ Zip:_____

Marital Status: _____ Significant Others Name: _____ # of Children: _____

Occupation:_____ Who may we thank for referring you to our office:_____

Have you ever had Chiropractic care before? Yes □ No □ Date: _____

Is this injury/illness related to: Automobile Accident □ Work Injury □ Did you file a claim? _____

If you were involved in a legal case please inform us so that we can acquire the essential injury information

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort, others are interested in having the cause of the problem as well as the symptoms corrected and relieved. Your Doctor will weigh your needs and desires when recommending your treatment program. **Please circle the type of care that best meets your needs.**

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please initial the blank line or check the box as directed

HIPPA

_____Initial The undersigned does hereby acknowledge that he/she can receive a copy of this offices notice of privacy practices pursuant to HIPPA and has been advised that a full copy of his office's HIPAA compliance manual is billable upon request. The undersigned does hereby consent to the use of his/her health information in a manner consistent with the notice of privacy practices to HIPAA, the HIPAA compliance manual, state law, and federal law. A full copy of Barton Chiropractic Notice of Privacy Practices is available upon request. Information regarding my health information may be disclosed to: _____this authorization expires on ____/____/____

Photos and Recordings

_____ Initial I am aware that all calls and verbal conversations may be recorded for quality and training purposes. We are proud of our patients and the progress they make while under care! There's nothing we enjoy more than celebrating our patients' successes along with them and when something good is happening in our lives, we feel inclined to share it with others right? If the moment arises, we would love to share your photo, story, or progress on our social media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results! Please inform us if you would like to refrain from any images or xrays being used.

X-ray Release and Consent

_____Initial It is not unusual for our office to take digital x-rays in the process of determining how we can best help you. We utilize state of the art digital full spine weight bearing X-Rays. They are highly technical to analyze, but you are more than welcome to a copy of them at any time.

□ I am pregnant at this time and/or I have a medical condition which contradicts the utilization of digital x-rays
□ I am not pregnant at this time and/or I do not have a known medical condition contradicting digital x-rays

____ Initial

Fee Schedule

I understand that regardless of insurance coverage I am responsible for all charges incurred at the time of service unless previous arrangements have been made. While there is no charge for the consultation, the exam may range
□ from $46-195 and x-rays could range from $42-500 depending on the type and quantity of x-rays necessary. Should you have any financial concerns please feel free to check the box and we will be sure to let you know specifically what your estimated charges are before they are incurred that way there are no surprises.

Informed Consent

_____ Initial

I hereby request and consent to the performance of chiropractic examinations, adjustments, and any other associated procedures on me by the chiropractic doctors of Barton chiropractic. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based on the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association Guidelines. I have read (or had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Parental Consent for Minor Patient (if applicable):

Patient Name: _____Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____ do hereby consent, authorize and request Barton Chiropractic to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from such treatment In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.
Signature: _____Relationship to Patient: _____

Insurance

Please let us take a copy of your insurance card and ID to have on file

_____ Initial

Statements will be provided for individuals who submit their own bills ensuring that if your insurance provider pays for your care, they will send the reimbursement check directly to you. We would be more than happy to verify what benefits you might have eligible in this office and assist with billing if necessary, but insurance is not a guarantee of coverage. **Assignment of Benefits (under California State Insurance Code # 10133)**: You are instructed to pay directly to the below doctor at his/her office for all professional services rendered to me by his/her office. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid accounts for hospital, diagnostic, and consultant services. **Acknowledgement of Insurance Billing:** Our office will submit any insurance billing on a standardized HCFA 1500 via email or electronic billing when possible. As stated in box 12 and 13 of the printed billing when printed or sent electronically, the box states signature on file. This signature serves as signature on file. Box 12: reads: patients or authorized persons signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below. Box 13 reads: insureds or authorized persons signature: I authorize payment of medical benefits to be undersigned physician or supplier for services described on this billing.

I attest that the information on this form, and those preceding, is true and accurate to the best of my knowledge.

Signature of Patient or Representative: _____ Date: _____