Patient Health Record - Minor

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 17 YEARS OF AGE

ABOUT THE CHILD

NAME: | DATE:

PREFERRED NAME / NICKNAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH: | AGE: | GENDER: M F

SIBLING'S NAMES & AGES:

PEDIATRICIAN / FAMILY DOCTOR NAME:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME(S):

ADDRESS:

□ SAME AS ABOVE

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

EMPLOYER NAME:

WORK PHONE: | POSITION TITLE:

Your Health Solutions
2805 N Center, PO Box 305
Maryville, IL 62062
(618) 855-8105

CHIROPRACTIC EXPERIENCE

HOW DID YOU HEAR ABOUT OUR OFFICE?

□ INSURANCE □ PREVIOUS PATIENT
□ INTERNET SEARCH □ REFERRAL:_____
□ YOUR HEALTH SOLUTIONS WEBSITE □ SIGN / DRIVE BY
□ PHONE BOOK □ OTHER:_____

HAS YOUR CHILD EVER BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? □ YES □ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

CHIROPRACTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

□ ILLNESS □ INJURY □ WELLNESS

IF CONDITION, PLEASE DESCRIBE:

IS THIS PROBLEM:

□ CONSTANT □ FREQUENT □ OCCASIONAL

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

□ AUTO □ FALL □ HOME INJURY □ SPORTS
□ OTHER:_____

HOW DID THIS CONDITION START?

□ GRADUALLY □ POST INJURY □ SUDDENLY

WHEN? _____

IS THIS CONDITION:

□ ABOUT THE SAME □ GETTING WORSE
□ GETTING BETTER

DOES THIS CONDITION INTERFERE WITH:

□ DAILY ROUTINE □ SLEEP
□ EATING □ WALKING
□ HOBBIES / SPORTS □ WORK / SCHOOL
□ OTHER:_____

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? □ YES □ NO

HAS YOUR CHILD SEEN OTHER DOCTORS FOR THIS CONDITION? □ YES □ NO

DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT / TESTING (X-RAYS, MRI, CT SCAN):

RESULTS:

PATIENT NAME:
DATE:

"It is easier to build strong children than repair broken men."

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 17 YEARS OF AGE

GENERAL HISTORY

DOES YOUR CHILD HAVE A BALANCED DIET? □ YES □ NO

DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS? □ YES □ NO

DOES YOUR CHILD SLEEP WELL? □ YES □ NO

DOES YOUR CHILD SLEEP ON HIS/HER:
□ SIDE □ STOMACH □ BACK

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? □ YES □ NO

DESCRIBE ANY AND ALL REACTIONS TO VACCINE(S):

LIST PRESCRIPTION MEDICATION / VITAMINS YOUR CHILD HAS TAKEN:

LIST ANY ALLERGIES YOUR CHILD HAS:

HEALTH HISTORY

THE EFFECTS OF SUBLUXATION CAN BE BROAD AND FAR REACHING. THEY CAN SHOW UP AS OTHER HEALTH CONCERNS. PLEASE MARK ALL CONDITIONS / SYMPTOMS YOUR CHILD HAS EXPERIENCED:

□ ACID REFLUX
□ ALLERGIES
□ ASTHMA
□ BED WETTING
□ COLIC
□ CONSTIPATION
□ DIARRHEA
□ DIFFICULT WEIGHT GAIN
□ DIZZINESS
□ EAR INFECTIONS
□ FEVERS
□ FREQUENT COLDS/COUGHS/FLU
□ HEADACHES
□ HYPERACTIVITY
□ LEARNING DISORDERS
□ LOW BACK PAIN
□ NECK PAIN
□ POOR COORDINATION
□ SEIZURES
□ SHORTNESS OF BREATH
□ SLEEPING DIFFICULTIES
□ UPPER BACK PAIN
□ URINARY PROBLEMS
□ WEAKNESS

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR CHILD'S FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

F = FATHER M = MOTHER
G = GRANDPARENTS S = SIBLINGS

AUTOIMMUNE DISEASES □ M □ F □ S □ G
BACK PROBLEMS □ M □ F □ S □ G
CANCER: TYPE_____ □ M □ F □ S □ G
DEPRESSION □ M □ F □ S □ G
DIABETES □ M □ F □ S □ G
HEART DISEASE □ M □ F □ S □ G
HIGH BLOOD PRESSURE □ M □ F □ S □ G
HIGH CHOLESTEROL □ M □ F □ S □ G
LIVER DISEASE □ M □ F □ S □ G
LUNG PROBLEMS □ M □ F □ S □ G
NECK PROBLEMS □ M □ F □ S □ G
OSTEOARTHRITIS □ M □ F □ S □ G
RHEUMATOID ARTHRITIS □ M □ F □ S □ G
SCOLIOSIS □ M □ F □ S □ G
SEIZURES □ M □ F □ S □ G

OTHER:_____

IF YOU HAVE ANY OTHER CONCERNS NOT PREVIOUSLY LISTED ON THESE FORMS, PLEASE WRITE THEM BELOW.

CONSENT TO TREAT A MINOR

I HEREBY REQUEST AND AUTHORIZE DR. BRYAN W. REID, D.C. TO PERFORM DIAGNOSTIC TESTS AND RENDER CHIROPRACTIC ADJUSTMENTS AND OTHER TREATMENT TO (PRINT MINOR'S NAME) _____.

THIS AUTHORIZATION ALSO EXTENDS TO ALL OTHER DOCTORS AND OFFICE STAFF 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 HEALTHCARE SERVICES FOR THE MINOR 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 SELECT AND AUTHORIZE THIS CARE SHOULD BE REVOKED OR MODIFIED IN ANY WAY, I WILL IMMEDIATELY NOTIFY THIS OFFICE.

SIGNATURE: DATE:

PRINTED NAME: RELATIONSHIP TO PATIENT:

THANK YOU FOR CHOOSING YOUR HEALTH SOLUTIONS AND HELPING US TO CONTINUE ON OUR MISSION TO
GROW A HEALTHIER COMMUNITY, ONE FAMILY AT A TIME!

PATIENT NAME:
DATE:

"As the twig is bent, so grows the tree."

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE

BIRTH HISTORY

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? □ YES □ NO

DID YOU SUFFER ANY TRAUMAS, FALLS OR ACCIDENTS? □ YES □ NO

PLEASE EXPLAIN:

DURING PREGNANCY DID YOU USE:

□ MEDICATIONS □ TOBACCO / ALCOHOL □ VITAMINS

IF YES, PLEASE EXPLAIN:

ULTRASOUND DURING PREGNANCY?

□ YES □ NO NUMBER:_____

LOCATION OF BIRTH:

□ BIRTHING CENTER □ HOME □ HOSPITAL

WHAT WAS THE BABY'S GESTATIONAL AGE AT BIRTH? _____:WEEKS

DESCRIBE YOUR LABOR / DELIVERY, MARK ALL THAT APPLY:

□ CHEMICALLY INDUCED LABOR □ FORCEPS
□ C-SECTION DELIVERY □ PREMATURE DELIVERY
□ DOCTOR ASSISTED LABOR □ SPONTANEOUS
□ DOCTOR PULLED/TWISTED BABY □ VACUUM EXTRACTION
□ DRUG FREE □ VAGINAL

DESCRIBE ANY COMPLICATION EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT: _____ BIRTH LENGTH: _____

WAS BABY ALERT & RESPONSIVE WITHIN 12 HRS OF DELIVERY? □ YES □ NO

DID YOU BREASTFEED THE BABY? □ YES □ NO

IF YES, HOW LONG?

DID YOU HAVE ANY DIFFICULTY WITH LATCHING OR LACATION? □ YES □ NO

PREFERENCE FOR ONE SIDE WHILE FEEDING? □ YES □ NO

DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAMA?

□ BRUSING □ LACK OF USE OF ONE ARM
□ CORD AROUND NECK □ ODD SHAPED HEAD
□ FAST/EXCESSIVELY LONG BIRTH □ RESPIRATORY DISTRESS
□ HEAD ROTATED TO ONE SIDE □ STUCK IN THE BIRTH CANAL

WAS THERE A PRESENCE OF:

□ CYANOSIS (BLUE) □ JAUNDICE (YELLOW)

GROWTH & DEVELOPMENT

DID YOU OR YOUR CHILD'S PEDIATRICIAN EVER FEEL YOUR CHILD WAS BEHIND ON ANY MILESTONES (I.E.: CRAWL, HOLD HEAD UP, SIT ALONE, TALK, TEETHE, WALK)? □ YES □ NO

IF YES, PLEASE EXPLAIN:

HOW MANY TIMES A WEEK DOES YOUR CHILD EAT:

FAST FOOD: _____ SODA: _____

CANDY / COOKIES: _____

ARE YOU AWARE OF ANY FOOD ALLERGIES OR INTOLERANCE? □ YES □ NO

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? □ YES □ NO

IF YES, HOW MANY TIMES?

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? □ YES □ NO

IF YES, PLEASE EXPLAIN:

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).

WAS THIS THE CASE FOR YOUR CHILD? □ YES □ NO

IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT OR MAJOR INJURY? □ YES □ NO

IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS? □ YES □ NO

IF YES, PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR? □ YES □ NO

IF YES, PLEASE EXPLAIN:

AVERAGE NUMBER OF HRS OF TV / VIDEO GAMES PER WEEK? _____

IN THE HOME, ARE THERE ANY:

SMOKERS: □ YES □ NO
INDOOR PETS: □ YES □ NO

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INFORMED CONSENT TO CARE

YOU ARE THE DECISION MAKER FOR YOUR HEALTH CARE. PART OF OUR ROLE IS TO PROVIDE YOU WITH INFORMATION TO ASSIST YOU IN MAKING INFORMED CHOICES. THIS PROCESS IS OFTEN REFERRED TO AS "INFORMED CONSENT" AND INVOLVES YOUR UNDERSTANDING AND AGREEMENT REGARDING THE CARE WE RECOMMEND, THE BENEFITS AND RISKS ASSOCIATED WITH THE CARE, ALTERNATIVES, AND THE POTENTIAL EFFECT ON YOUR HEALTH IF YOU CHOOSE NOT TO RECEIVE THE CARE.

WE MAY CONDUCT SOME DIAGNOSTIC OR EXAMINATION PROCEDURES IF INDICATED. ANY EXAMINATIONS OR TESTS CONDUCTED WILL BE CAREFULLY PERFORMED BUT MAY BE UNCOMFORTABLE.

CHIROPRACTIC CARE CENTERALLY INVOLVES WHAT IS KNOWN AS A CHIROPRACTIC ADJUSTMENT. THERE MAY BE ADDITIONAL SUPPORTIVE PROCEDURES OR RECOMMENDATIONS AS WELL. WHEN PROVIDING AN ADJUSTMENT, WE USE OUR HANDS OR AN INSTRUMENT TO REPOSITION ANATOMICAL STRUCTURES, SUCH AS VERTEBRAE. POTENTIAL BENEFITS OF AN ADJUSTMENT INCLUDE RESTORING NORMAL JOINT MOTION, REDUCING SWELLING AND INFLAMMATION IN A JOINT, REDUCING PAIN IN THE JOINT, AND IMPROVING NEUROLOGICAL FUNCTIONING AND OVERALL WELL-BEING.

IT IS IMPORTANT THAT YOU UNDERSTAND, AS WITH ALL HEALTH CARE APPROACHES, RESULTS ARE NOT GUARANTEED, AND THERE IS NO PROMISE TO CURE. AS WITH ALL TYPES OF HEALTH CARE INTERVENTIONS, THERE ARE SOME RISKS TO CARE, INCLUDING, BUT NOT LIMITED TO: MUSCLE SPASMS, AGGRAVATING AND/OR TEMPORATY INCREASE IN SYMPTOMS, LACK OF IMPROVEMENT OF SYMPTOMS, BURNS AND/OR SCARRING FROM ELECTRICAL STIMULATION AND FROM HOT OR COLD THERAPIES, INCLUDING BUT NOT LIMITED TO HOT PACKS AND ICE, FRACTURES (BROKEN BONES), DISC INJURIES, STROKES, DISLOCATIONS, STRAINS, AND SPRAINS. WITH RESPECT TO STROKES, THERE IS A RARE BUT SERIOUS CONDITION KNOWN AS AN "ARTERIAL DISSECTION" THAT TYPICALLY IS CAUSED BY A TEAR IN THE INNER LAYER OF THE ARTERY THAT MAY CAUSE THE DEVELOPMENT OF A THROMUS (CLOT) WITH THE POTENTIAL TO LEAD TO A STROKE. THE BEST AVAILABLE SCIENTIFIC EVIDENCE SUPPORTS THE UNDERSTANDING THAT CHIROPRACTIC ADJUSTMENT DOES NOT CAUSE A DISSECTION IN A NORMAL, HEALTHY ARTERY. DISEASE PROCESSES, GENETIC DISORDERS, MEDICATIONS, AND VESSEL ABNORMALITIES MAY CAUSE AN ARTERY TO BE MORE SUSCEPTIBLE TO DISSECTION. STROKES CAUSED BY ARTERIAL DISSECTIONS HAVE BEEN ASSOCIATED WITH OVER 72 EVERYDAY ACTIVITIES SUCH AS SNEEZING, DRIVING, AND PLAYING TENNIS.

ARTERIAL DISSECTIONS OCCUR IN 3-4 OF EVERY 100,000 PEOPLE WHETHER THEY ARE RECEIVING HEALTH CARE OR NOT. PATIENTS WHO EXPERIENCE THIS CONDITION OFTEN, BUT NOT ALWAYS, PRESENT TO THEIR MEDICAL DOCTOR OR CHIROPRACTOR WITH NECK PAIN AND HEADACHE. UNFORTUNEATELY A PERCENTAGE OF THESE PATIENTS WILL EXPERIENCE A STROKE.

THE REPORTED ASSOCIATION BETWEEN CHIROPRACTIC VISITS AND STROKE IS EXCEEDINGLY RARE AND IS ESTIMATED TO BE RELATED IN ONE IN ONE MILLION TO ONE IN TWO MILLION CERVICAL ADJUSTMENTS. FOR COMPARISON, THE INCIDENCE OF HOSPITAL ADMISSION ATTRIBUTED TO ASPIRIN USE FROM MAJOR GI EVENTS OF THE ENTIRE (UPPER AND LOWER) GI TRACT WAS 1219 EVENTS/ PER ONE MILLION PERSONS/YEAR AND RISK OF DEATH HAS BEEN ESTIMATED AS 104 PER ONE MILLION USERS.

IT IS ALSO IMPORTANT THAT YOU UNDERSTAND THERE ARE TREATMENT OPTIONS AVAILABLE FOR YOUR CONDITION OTHER THAN CHIROPRACTIC PROCEDURES. LIKELY, YOU HAVE TRIED MANY OF THESE APPROACHES ALREADY. THESE OPTIONS MAY INCLUDE, BUT ARE NOT LIMITED TO: SELF-ADMINISTERED CARE, OVER-THE-COUNTER PAIN RELIEVERS, PHYCIAL MEASURES AND REST, MEDICAL CARE WITH PRESCRIPTION DRUGS, PHYSICAL THERAPY, BRACING, INJECTIONS, AND SURGERY. LASTLY, YOU HAVE THE RIGHT TO A SECOND OPINION AND TO SECURE OTHER OPINIONS ABOUT YOUR CIRCUMSTANCES AND HEALTH CARE AS YOU SEE FIT.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CHIROPRACTIC CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CHIROPRACTIC CARE FROM THIS OFFICE.

PATIENT NAME:	SIGNATURE:	DATE:
PARENT OR LEGAL GUARDIAN:	SIGNATURE:	DATE:

FOR DOCTOR ONLY: VERBAL CONSENT OBTAINED: □ YES □ NO

SIGNATURE OF DOCTOR: DATE:

Release of PHI & Notice of Privacy Policy

RELEASE OF INFORMATION

IF YOU WOULD LIKE YOUR PERSONAL HEALTH INFORMATION (PHI) TO BE SHARED WITH ANY OTHER PERSON (INCLUDING SPOUSE OR ADULT CHILD) PLEASE FILL IN THE INFORAMTION BELOW.

WE WILL ASK QUESTIONS OF THIS PERSON TO VERIFY THEIR RELATIONSHIP WITH YOU, INCLUDING YOUR DATE OF BIRTH.

NAME	RELATIONSHIP
1._____	_____
2._____	_____
3._____	_____

THIS AUTHORIZATION IS EFFECTIVE UNLESS REVOKED OR TERMINATED BY THE PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE THROUGH:

□ DATE _____/_____/_____
□ NO EXPIRATION

NOTICE OF PRIVACY POLICY

PROTECTING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION IS IMPORTANT TO US. DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION WITHOUT AUTHORIZATION IS STRICTLY LIMITED TO DEFINED SITUATIONS THAT INCLUDE EMERGENCY CARE, QUALITY ASSURANCE ACTIVITIES, PUBLIC HEALTH, RESEARCH, AND LAW ENFORCEMENT ACTIVITIES. ANY OTHER DISCLOSURES FOR THE PURPOSES OF TREATMENT, PAYMENT OR PRACTICE OPERATIONS WILL BE MADE ONLY AFTER OBTAINING YOUR CONSENT.

- YOU MAY REQUEST RESTRICTIONS ON YOUR DISCLOSURES.
- YOU MAY INSPECT AND RECEIVE COPIES OF YOUR RECORDS WITHIN 30 DAYS WITH A REQUEST.
- YOU MAY REQUEST TO VIEW CHANGES TO YOUR RECORDS.
- IN THE FUTURE, WE MAY CONTACT YOU FOR APPOINTMENT REMINDERS, ANNOUNCEMENTS AND TO INFORM YOU ABOUT OUR PRACTICE AND ITS STAFF.

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP WITH MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY OR INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN'S CERTIFICATIONS.

I HAVE BEEN PROVIDED A COPY OF THE HIPPA NOTICE OF PRIVACY PRACTICES FOR THIS PRACTICE FOR MY REVIEW. I UNDERSTAND I CAN REQUEST A COPY OF THE HIPPA NOTICE OF PRIVACY PRACTICES, AT ANY TIME. I ALSO UNDERSTAND THAT I CAN REQUEST, IN WRITING, THAT YOU RESTRICT HOW MY PERSONAL INFORAMTION IS USED AND / OR DISCLOSED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS INFORMATION, PLEASE DO NOT HESITATE TO CONTACT OUR OFFICE.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

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Billing, Payment and Collection Policies

WE OFFER THE FOLLOWING TWO OPTIONS AS FORMS OF PAYMENT:

#1: NON-INSURANCE OPTION

SELFPAY / NON-INSURANCE PAYORS:

PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE.

#2: INSURANCE OPTION

AS A COURTESY, THE BILLING DEPARTMENT WILL FILE CLAIMS TO YOUR INSURANCE COMPANY FOR SERVICES RENDERED.

IT IS THE PATIENT'S RESPONSIBILITY TO PRESENT ALL CURRENT INSURANCE CARDS AT TIME OF SERVICE. MANY INSURANCE COMPANIES HAVE A TIMELY FILING LIMIT THAT DOES NOT ALLOW BACK-BILLING.

CO-PAY IS DUE AT TIME OF SERVICE.

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL FROM YOUR PRIMARY DOCTOR, IT IS YOUR RESPONSIBILITY TO AQUIRE THAT INFORMATION PRIOR TO YOUR INITIAL TREATMENT. WE ARE NOT RESPONSIBLE FOR KNOWING IF YOU NEED A REFERRAL OR NOT.

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE DIRECT PAYMENT OF CHIROPRACTIC BENEFITS TO THIS OFFICE FOR SERVICES RENDERED BY THE PHYSICIAN IN PERSON OR UNDER THE PHYSICIAN'S SUPERVISION.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS.

THIS OFFICE DOES NOT PROMISE THAT ANY INSURANCE COMPANY WILL PAY. IN THE EVENT THAT THE INSURANCE COMPANY DISPUTES OR REJECTS THE CLAIM, IT WILL BE THE PATIENT'S RESPONSIBILITY TO PAY ALL THE CHARGES AND PURSUE REIMBURSEMENT FROM THE INSUIRANCE COMPANY ON HIS / HER OWN.

CANCELLATION / NO SHOW

A 24 HOUR NOTICE MUST BE GIVEN IF YOU ARE UNABLE TO KEEP AN APPOINTMENT.

IN THE CASE OF A SHORT NOTICE OR NO NOTICE CANCELLATION, A $25 CANCELLATION FEE WILL BE CHARGED TO THE PATIENT ACCOUNT.

PAST DUE ACCOUNTS

AFTER 60 DAYS OF NON-PAYMENT, A $25 LATE FEE WILL BE ADDED AND COMPOUND MONTHLY.

IF NECESSARY, THE ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY AND A COLLECTION FEE OF 30% WILL BE ADDED TO YOUR BALANCE.

AS A LAST RESORT, LEGAL ACTION WILL BE TAKEN. ALL REASONABLE ATTORNEYS AND COURT FEES INCURRED TO COLLECT PAST DUE ACCOUNTS WILL BE ADDED TO THE ACCOUNT AND THE PATIENT WILL BE RESPONSIBLE.

TERMINATION

FAILURE TO MAKE PAYMENT COULD JEOPARDIZE YOUR PATIENT / PROVIDER RELATIONSHIP. YOU MAY BE NOTIFIED BY MAIL OF INTENT TO TERMINATE THE RELATIONSHIP AS A RESULT OF NON-PAYMENT FOR SERVICES RENDERED.

PAYMENT COMMITMENT

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO EACH OF THE ABOVE POLICIES AND CHOOSE THE PAYMENT OPTION INDICATED BELOW:

□ NON-INSURANCE PAYMENT OPTION. I WILL PAY IN FULL AT THE TIME OF SERVICE.

□ INSURANCE PAYMENT OPTION. PLEASE FILE CLAIMS WITH THE TYPE OF INSURANCE I HAVE SELECTED BELOW:

- □ AUTO INSURANCE
- □ HEALTH INSURANCE
- □ WORK COMP INSURANCE

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

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