# Major Chiropractic & Sports Science, Ltd.

## New Patient Registration

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Gender: ___M ___F Date of Birth: _____ Age: _____ Marital Status: __M__ S __ D__ W

# of children: _____ Parent or Spouse's Name: _____

Employer/School: _____

Employer/School Phone: _____ Occupation: _____

Primary Care Physician (PCP): _____

Address/Phone: _____

Who may we thank for referring you? _____

**Accident Information**:

Date of Injury: _____ Type of accident: ___ Auto ___ Work ___ Home ___ Other _____

To whom have you made a report of the accident? ___ Auto Ins. ___ Employer ___ Work Comp. ___ Other _____

Insurance Company: _____ Contact: _____ Claim #: _____

**Insurance Information:**

Subscriber Name: _____ Subscriber's Date of Birth: _____

Insurance Company: _____ Policy # _____ Group # _____

Is there secondary insurance? ___Y ___N

Insurance Company: _____ Policy # _____ Group # _____

# Major Chiropractic & Sports Science, Ltd.

## Terms of Acceptance

### 1. Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient of Major Chiropractic & Sports Science, Ltd., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

### 2. Missed Appointments:

There is a $40 missed appointment fee charged for all appointments that are not cancelled 24 hours prior to the scheduled visit.

### 3. Consent to Evaluate and Treat a Minor (If under 18 years of age):

I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

### 4. Communications

We use an automated system to keep you informed of upcoming appointments via text and/or e-mail.

If you do not wish to receive these reminders, please initial: _____

I have read and fully understand the above statements.

Date: _____/_____/_____

Signature: _____

Relationship: Self / Parent / Guardian

# Major Chiropractic & Sports Science, Ltd.

## Doctor's Lien/Assignment of Benefits

1. I hereby assign to this office my rights to receive payments from negligent parties, insurance companies, my attorney, or any other party obligated to pay me any sums.
2. I authorize this office to release any information to any insurance company, adjuster, or attorney that will assist in the payment of a claim.
3. I hereby authorize and direct my attorney to directly pay said doctor, such sums as may be due and owing him for medical services rendered me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to my attorney or myself as the result of the injuries for which I have treated or injuries in connection therewith.
4. I agree never to rescind this document and that a rescission will not be honored by my attorney, if substituted in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.
5. I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.
6. I fully understand and agree that insurance policies are an arrangement between an insurance company and me. I will be responsible for any expenses not paid by insurance.
7. A photocopy of this form shall be valid as the original.

Date: _____/_____/_____

Signature: _____

Relationship: Self / Parent / Guardian

# Major Chiropractic & Sports Science, Ltd.

**Patient Acknowledgement of the**
***Notice of Patient Privacy Policy***

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

By signing this document, I acknowledge that you have offered me a copy of your *Notice of Patient Privacy Policy.* The *Notice of Patient Privacy Policy* contains a more complete description of the uses and disclosures of my health information.

I understand that **Major Chiropractic & Sports Science, Ltd.** has the right to change its *Notice of Patient Privacy Policy* from time to time and that I may contact **Major Chiropractic & Sports Science, Ltd.** at any time at the address above to obtain a current copy of the *Notice of Patient Privacy Policy.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound by such restrictions.

Date: _____/_____/_____

Signature: _____

Relationship: Self / Parent / Guardian