PATIENT INTAKE FORM

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x--ray(s), and physical therapy techniques on me (or on the patient named below of which I am legally responsible which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back--up for the doctor of chiropractic; ***Greg Vrankovich, D.C., Laura Landgraf, D.C, Andrew Mukai, D.C. and Alison Main, D.C.***

I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. 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. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest. I have had an opportunity to discuss with the doctor named below and/or with office personal the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

_____ **INITIAL**

I have read ( ) or have read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is my best interest to undergo the chiropractic treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ **INITIAL**

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to HealthFit Chiropractic Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me for purposes relating to the payment of services rendered to me and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____ **INITIAL**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of HealthFit Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ **INITIAL**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

With my permission below, release my protected health information to the following person(s) or entity:

Name_____ Relationship _____

PLEASE CHECK ALL THAT APPLY

☐ That messages may be left on an answering machine

☐ That calls be made to cellular phone numbers and messages may be left at cellular phone numbers given

☐ That information may be given in person either verbally or in writing to any of the persons listed above

☐ That information may be discussed over the telephone with persons listed above

☐ That information may be given by fax to any of the persons listed above

By signing this form, I authorize you to use and disclose protected health information. This authorization shall be in force and effective until revoking in writing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the office.

_____ _____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE | PRINTED NAME OF PATIENT OR REPRESENTATIVE | DATE

TELL US ABOUT YOURSELF

First Name _____ MI _____ Last Name _____

☐ Male ☐ Female Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Email _____ Phone #_____ Cell # _____

Referred by _____

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Job Duties _____

EMERGENCY CONTACT

Name_____ Contact Number _____ Relationship _____

Name_____ Contact Number _____ Relationship _____

INSURANCE INFORMATION

Insurance Carrier_____ Insurance Plan _____ Contact Number _____

Group Number _____Policy Number _____

Primary Insurer's Name _____ Date of Birth _____ Relationship _____

Primary Care Physician _____ Contact Number_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO THE DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ Insurance Company to pay by check made out to and mailed directly to:
HealthFit Chiropractic Center, PO Box 11105, Oakland, CA 94611

Or if my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:
HealthFit Chiropractic Center, PO Box 11105, Oakland, CA 94611

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above--mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non--covered services and/or fees over and above the insurance payment or as required by my insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

I hereby authorize the insurance carrier above to make payments directly to HealthFit Chiropractic Center and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll In another insurance plan. It is my responsibility to notify HealthFit Chiropractic Center; otherwise I will be responsible for payment.

_____ _____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE | PRINTED NAME OF PATIENT OR REPRESENTATIVE | DATE