Hill Chiropractic
305 W 1st Ave, Ste A
Crossett, AR 71635
870-304-9306

I, _____ give permission to Dr. Hill and staff to speak with the following person(s) regarding my healthcare:

Name of person	Relation	Phone #

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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Informed Consent to Chiropractic Examination and Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, and/or physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by Brandi Hill, D.C.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (1 in 3 million chance). We screen our patients for indications that they are candidates for chiropractic manipulation to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in the best interest of the patient.

I have had an opportunity to discuss with the doctor the nature, purpose and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, 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.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of my last menstrual period_____.

_____
Printed name of patient

_____ _____
Signature of patient Date

_____ _____
Signature of patient's representative (if a minor) Date

HIPPAA

This notice describes how your health information may be used and how you can gain access to this information. Please review carefully.

Our Promise to You Our Valued Patient….

We want to assure you that we take the new Federal (HIPPA-Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you tat we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to state and federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of obtaining payment for services and conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will allow us to provide a description of your health information usage from November 2011 and forward. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for your request.

You have a right to obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right ot change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____ Date_____

Patient Signature

CONFIDENTIAL PRACTICE MEMBER INFORMATION

Welcome. This information is important, please print. Date: _____

Name: _____ DOB: _____ SSN: ___-___-____

Address: _____ City: _____ Zip: _____

Email: _____ Home #: _____ Cell #: _____

Sex: M or F Marital Status: S M D W Children: Y or N If yes, how many?: _____

Employer: _____ Occupation: _____ Work #: _____

Employer address: _____ City: _____ Zip: _____

Have you ever been to a chiropractor before? _____ If so, when? _____

Do you have any symptoms? If so, what are they and how have they affected your life _____

_____

Are you currently under a doctor's care? _____ If yes, explain: _____

_____

If this is work related have you reported it to your employer? Y or N

Is this related to an auto accident? Y or N

Females: Are you pregnant? Y or N

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to the patient which is not considered to be a covered by third party insurers or payers.

If the doctor determines that services are necessary, all charges are payable when rendered.

What form of payment will you use? Cash Check Credit/Debit

_____ _____

Patient Signature Date

I understand and agree that health and accident insurance policies are an agreement between the carrier and me. I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. I also understand if I suspend or terminate my care at this office, any outstanding charges for professional services rendered will be immediately due and payable. I hereby authorize the doctors at Hill Chiropractic and whomever they may designate as their assistants to administer any care as they deem necessary. I certify that the information I have provided is true and correct.

_____ _____

Signature Date

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I (We), the undersigned patient and/or responsible party hereby jointly authorize this office, it's agents/employees to release and disclose all or part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I (We), authorize the release and disclosure of any and all of my medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I (We) may be entitled. I (We) authorize this office and/or its employees to release, via fax, medical records which are needed in order to provide patient with the most appropriate medical care.

I (We), authorize and request that payment of any third-party or insurance company benefits be made to this office for any services furnished to the patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

_____ _____

Signature Date

TERMS OF ACCEPTANCE

When an individual seeks chiropractic health care and we accept this individual for such care, it is essential for both to be working towards the same objective.

Chiropractic has one goal: to eliminate subluxations (misalignments) within the spinal column which interfere with the nervous system causing pain and other symptoms. It is important that you understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings we will recommend that you seek the services of a health care provider who specializes in that area.

Our practice objective is to correct spinal subluxations, eliminate interference in the nervous system. Our method is specific adjusting of the vertebrae, deep tissue therapy, exercise, and acupuncture.

I have read and fully understand the above statements

_____ _____

Patient Signature Date