Notice of Patient Privacy Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

This Office/Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the health care you receive from the Practice. The creation of a record detailing the care and services your receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding tour PHI.

- The Office/Practice may use and/or disclose your PHI for the following purposes:

a. **Health care** - In order to provide you with the health care you require, the Office/Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that the may understand your health condition and needs. For example, a chiropractor adjusting you for a subluxation in the cervical spine may need to know the results of your latest chiropractic examination by this office.

b. **Payment** - In order to get paid for services provided to you, the Office/Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice, or you, can be properly reimbursed. The Practice may also need to tell your insurance plan about the care you are going to receive so that it can determine whether or not it will cover the health care expenses.

c. **Health Care Operations** - In order for the Office/Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

- The Office/Practice may also use an/or disclose your PHI without your specific authorization in the following additional instances:

a. **De-identified Information** - Information that does not identify you and, even without your name, cannot be used to identify you.

b. **Business Associates** - To a business associate if the Office/Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

c. **Personal Representative** - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

d. **Emergency Situations**-

1. for the purpose of obtaining or rendering emergency treatment to you if the opportunity for you to object cannot be obtained due to your incapacity or emergent treatment circumstances and the treatment is consistent with your prior expressed preferences and is in your best interest. or

2. to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

e. **Public Health Activities** - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent serious harm.

f. **Abuse, Neglect or Domestic Violence** - To a government authority in the Office/Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will so so if it believes that the disclosure is necessary to prevent serious harm.

g. **Health Oversight Activities** - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

h. - For example, the Office/Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

i. **Law Enforcement Purpose** - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice believes your death was the result of criminal conduct.

j. **Coroner or Medical Examiner** - The Office/Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining you cause of death.

k. **Organ, Eye or Tissue Donation** - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

l. **Research** - If the Office/Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

m. **Avert a Threat to Health or Safety** - The Office/Practice may disclose your PHI if it believes disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public and disclosure is to an individual who is reasonably able to prevent or lessen the threat.

n. **Specialized Government Function** - This refers to disclosures of PHI that related primarily to military and veterans activity.

o. **Workers Compensation** - If you are involved in a Workers' Compensation claim, the Office/Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

p. **National Security and Intelligence Activities** - The Office/Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

q. **Military and Veterans** - If you are a member of the armed forces, the Office/Prac-

tice may disclose your PHI as required by the military command authorities.

r. **Fundraising** -In order to conduct or assist business associates and/or other institutionally related foundations raise funds for a charitable purpose, such as local hospital, the American Red Cross or other private or public disaster relief agency, Breast Cancer or AIDS-related research, etc., this Office/Practice may give out demographic information about you as well as any dates health care was provided to you without your specific authorization. However, if this Office/Practice does engage in any fundraising activity, it must include instructions how you may decline to receive further fundraising communications from the Office/Practice.

APPOINTMENT REMINDER

- The Office/Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG

- The Office/Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's located within the Practice's office suite. This information may be seen by, and is accessible to, other who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

- The Office/Practice may disclose to your family member, other relative, a close personal friend, or any other reason identified by you, your PHI directly relevant to such persons involvement with you care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or location) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases , the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Office/Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

(b) If you are not present, the Office/Practices will in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

- Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

- You have the right to:

(a) Revoke any Authorization in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Office/Practice is not obligated to agree to any requested restrictions.To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communication or PHI by alternative means or at alternative locations. You must make you request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the practice (unless the individual or the entirety that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the practice's denial, you will have the right to submit a written statement of the disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer.The request must state a time period which may not be longer then six years and mat not include dates before April 14, 2003. The request should indicate in what form you want the list (such as paper or electronic copy). The first list you request within a twelve month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Office/Practice upon request to the Practice's Privacy Officer.

(h) Complain to the Officer/Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Office/Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Gary R. Street, D.C. at 400 South West St, Olney, IL or via email at chiroad@otbnet.com.

PRACTICE'S REQUIREMENTS

- The Office/Practice:

(a) Is required by federal law to maintain the privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI

(b) Is required by State Law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is provided for under federal law

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

- This Notice is in effect as of March 25, 2003.

FINANCIAL GUIDELINES & PATIENT RESPONSIBILITY POLICIES

At Malina Chiropractic Clinic, we take great pride in offering the very best chiropractic care and personal attention to each of our patients. We believe that everyone benefits when definitive guidelines are agreed upon. Accordingly, we have prepared this material so that you will understand our policies prior to your appointment.

I am fully responsible for payment of any and all services incurred by me at this clinic. If I choose to use my insurance benefits, I am responsible for charges not covered or reimbursed by my insurance company.

In the event that I receive payment from my insurance company for services rendered, I agree to pay the full amount of payment to Malina Chiropractic Clinic.

We require a 2 hour notice for all missed appointments. This allows time for other patients to come in for care but did not have an available appointment. I am aware that there is a No Show/Cancellation fee of $15.00 for an office visit that is not canceled within 2 hours of the appointment.

At the time we verify your insurance benefits, your insurance company informs us that the verification is not a guarantee of benefits and is based on your specific policy and guidelines. On occasion, your insurance company may deny or pay for your services at a rate other than what they actually quoted. Therefore, it is important that you know your policy guidelines and become proactive in making calls to your insurance company regarding charges, disputes, coverage, etc. Our professional services are rendered to you, not the insurance company. Deductibles and Co-Pays are payable at the time of service. Any previous balance is expected to be paid at time of service. Please let us know of any changes to your insurance coverage as soon as possible.

I authorize my insurance carrier to assign and directly pay all insurance benefits to Malina Chiropractic Clinic. I also authorize agents of any hospital, treatment center or previous physicians to furnish the clinic with copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed.

There is an administrative fee of $25 for all disability, FMLA, and other forms/paperwork that you need to have filled out by the physician. Please allow 5-7 business days for paperwork to be completed.

If applicable, Malina Chiropractic Clinic has agreed to treat me with a Letter of Protection which guarantees payment of outstanding charges that accrue after my insurance benefits have been terminated for whatever reason. These charges will be paid out of the proceeds of any pending litigation in my case. I hereby direct my attorney or responsible party who controls the disbursement of funds after my litigation has been resolved to pay Malina Chiropractic Clinic in full for any unpaid balance.

I acknowledge that I have carefully read and understand the Financial Guidelines and Patient Responsibility Policies. A duplicate of this statement is considered the same as the original.

______________________________ ________________

Name (please print) Date of Birth

______________________________ ________________

Signature Today's Date

MALINA CHIROPRACTIC CLINIC

ASSIGNMENT OF INSURANCE BENEFITS AND DIRECTION TO PAY

I, ________________________________ hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay, MALINA CHIROPRACTIC CLINIC for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any policy of insurance and may only be revoked with the express written consent of MALINA CHIROPRACTIC CLINIC . This assignment of insurance benefits pertains to any and all professional services, including past services, provided by MALINA CHIROPRACTIC CLINIC in relation to my health insurance and/or motor vehicle accident of

This assignment of insurance benefits is provided so that MALINA CHIROPRACTIC CLINIC may attempt to collect any unpaid or overdue insurance benefits from the insurance carrier. This includes the assignment of any cause of action that might accrue against such insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to MALINA CHIROPRACTIC CLINIC needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize MALINA CHIROPRACTIC CLINIC to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

I understand that there may be services provided that may not be paid under the benefits of my insurance plan and therefore I am responsible to pay for these services outside of my co-pay amounts.

A copy of this agreement will be as valid as the original.

I have read and I do understand this assignment thoroughly.

Patient's signature ________________________________

Signature of Legal Guardian ____________________________ Date____________________
(when patient is a minor child)

X-RAY CONSENT FORM

I, ____________________________, hereby release MALINA CHIROPRACTIC CLINIC from complications that may arise from receiving any x-ray studies. I understand that inherent risk associated with exposure to x-rays. I understand the need for x-rays to properly diagnose and treat my condition.

ATTENTION FEMALE PATIENTS: I, ______________________, hereby certify to the best of my knowledge that I am not pregnant and release MALINA CHIROPRACTIC CLINIC of liability for any complications that may arise from receiving any x-ray studies. I understand the inherent risk associated with exposure to x-rays. I understand the need for x-rays to properly diagnose and treat my condition.

ATTENTION PARENTS: Please complete Parent Consent Form for minor children. I, ____________________________, being parent or legal guardian of ____________________________, hereby consent to the treatment and performance of diagnostic testing of this minor at MALINA CHIROPRACTIC CLINIC by Drs Clifford and Whitney Malina or any legal agent of this clinic.

Patient Signature ____ Date____________________

Parent Signature ____ Date ____________________

Witness ____ Date ____________________

Authorizations and Releases

NAME ______________________________ CASE # ______________________

Consent for Treatment

I, the undersigned, hereby authorize Dr.______________________________ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's Signature ______________________ **Date** ___/___/___ **Witness** ______________________

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature ______________________ **Date** ___/___/___ **Witness** ______________________

Request For Payment of Benefits To Provider of Care

I hereby authorize the ______________________ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: ______________________

the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature ______________________ **Date** ___/___/___ **Witness** ______________________

Attorney Representation and Protection of Balance

I, the undersigned patient am directing my Attorney, ______________________, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Patient's Signature ______________________ **Date** ___/___/___ **Witness** ______________________

Consent For Treatment of Minor

I hereby authorize ______________________, D.C., and whomever he/she may designate as his/her assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child) ______________________ (child's name) ______________________

Guardian's Signature ______________________ **Date** ___/___/___ **Witness** ______________________

X-Ray/Medical Records Release

I have requested the release of records of (patient's name) ______________________ which are a part of the records at (facility) ______________________

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to: (Name) ______________________ (Address) ______________________

Patient's Signature ______________________ **Date** ___/___/___ **Witness** ______________________

©Copyright 1996 Alignis, Inc. Version 2.1.

Malina Chiropractic Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

WELCOME

one — ABOUT YOU

Today's Date: ______ / ______ / ______ File #: ______

Patient Name: ______
LAST FIRST MI

What You Prefer To Be Called: ______ ❑ Male ❑ Female

Birthdate: ___ / ___ / ___ Age: ______ SS#: ______

Mailing Address: ______

______
CITY STATE ZIP

Home Phone #: (______) ______

Work Phone #: (______) ______ Ext: ______

Cell Phone #: (______) ______

E-mail Address: ______

Referred By: ______

Employer: ______ How Long? ______

Employer's Address: ______

______
CITY STATE ZIP

Occupation: ______

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ______

Do you have children? ❑ Yes ❑ No How many? ______

two — INSURANCE INFO

Primary Insurance

Co. Name: ______

Address: ______

______
CITY STATE ZIP

Phone #: (______) ______

Insured's ID#: ______

Group # (Plan, Local, or Policy #): ______

Insured's Name: ______

Relation: ______ Date of Birth: ___ / ___ / ___

Insured's Employer: ______

Secondary Insurance

Co. Name: ______

Address: ______

______
CITY STATE ZIP

Phone #: (______) ______

Insured's ID#: ______

Group # (Plan, Local, or Policy #): ______

Insured's Name: ______

Relation: ______ Date of Birth: ___ / ___ / ___

Insured's Employer: ______

three — ACCOUNT INFO

Person ultimately responsible for account

Name: ______

Relation: ______

Billing Address: ______

______
CITY STATE ZIP

SS #: ______

Drivers License #: ______

Work Phone #: (______) ______

Payment method: ❑ Cash ❑ Check

______ ___ / ___

❑ Credit Card - Enter card # above (if accepted)

______
Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four — IN EVENT OF EMERGENCY

Whom should we contact? ______

Relation: ______

Home Phone #: (______) ______

Work Phone #: (______) ______

Cell Phone #: (______) ______

Who is your Medical Doctor? ______

Medical Doctor's Phone #: (______) ______

PLEASE CONTINUE ON BACK

5 five — REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness

Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity

When did your condition/accident occur? ___/___/___ Where did your injury occur? ______________

Please explain what happened: ______________

Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.

Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: ______________

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: ______________

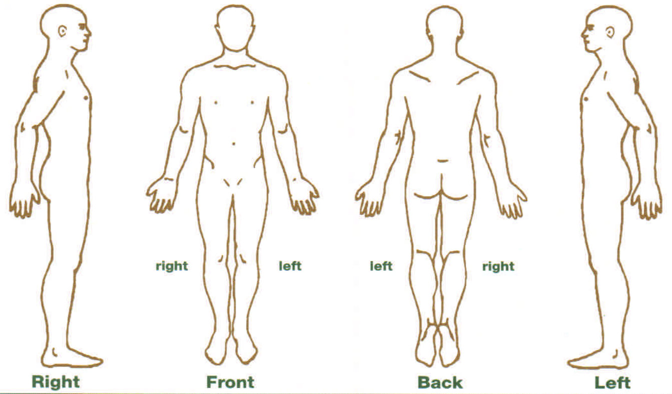
Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? ______________

Have you ever been treated by a Chiropractor? ❑Yes ❑No

Clinic or Dr's name: ______________

Clinic phone#: ______________



6 six — HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ______________

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis	**Y N** HIV+ / AIDS / ARC
Y N Shingles	**Y N** Cancer	**Y N** Frequent Neck Pain	**Y N** Glaucoma	**Y N** Anemia / Diabetes
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe / Frequent Headaches	**Y N** Kidney Problems
Y N Ulcers / Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema / Asthma	**Y N** Tuberculosis
Y N Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: ______________

List any past serious accidents with dates: ______________

Please list anything that you may be allergic to: ______________

Family Health History: ______________

Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes _____ hours per week

Do you smoke? ❑ No ❑ Yes How much? ______________ How long? __________

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___

For woman: Are you taking Birth Control? ❑ Yes ❑ No

Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? __________

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

PRINTED ON RECYCLED PAPER

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________ Date ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials	Date
______	___/___/___
Comments	
______	___/___/___
Comments	
______	___/___/___
Comments	

First Impression Forms, Inc. 1-800-99FORMS FORM # 2MCA1 Copyright ©2004