Welcome to Serenity Chiropractic and Wellness

Office Fee Schedule and Financial Policy

Services:

Consultation	n/c
Exams	$110.00
X-Rays	Referral
Adjustments	$55.00

Financial Policy

We are committed to providing you the best care possible in a caring environment, and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care *at the time of service*. At your report of findings, we will discuss various payment options based on your recommended care plan.

Health Insurance: If you have insurance that covers chiropractic, we provide you with a receipt for your insurance company to see that you have been treated here. This is not a guarantee of reimbursement. We are not in network with any insurance companies and do not file claims.

I have read and I understand the above policies.

_____

Patient Signature Date

Date _____
Name _____ Date of Birth _____Age _____ M/F
Address _____City _____ State _____ Zip _____
Phone H(__) _____ W(__)_____C/P(__)_____Email_____
Occupation_____ Employer(name/address)_____
Who is your primary care physician? _____
Have you ever received Chiropractic Care? Y/N When, Where?_____
Have you ever received Massage therapy Y/N How often: _____
Emergency Contact: Name _____ Relationship _____Phone_____

About Your Health

The human body is designed to be healthy. Unfortunately, for most of us, that is not always the case. Throughout life, events occur which damage and interfere with our good health.

Beginning with your examination and throughout your lifetime of regular chiropractic care, we will work together to remove these interferences and allow you to live the healthy, active life you deserve. This case history will reveal the layers of damage that have resulted in your current state of health.

Symptoms and Ill Health (Present State of Health)

Please list the symptoms you are now experiencing or have recently experienced and the approx date when they began:

1._____ ❑Sharp ❑Dull ❑Constant ❑Intermittent

2._____ ❑Sharp ❑Dull ❑Constant ❑Intermittent

3._____ ❑Sharp ❑Dull ❑Constant ❑Intermittent

What activities aggravate symptoms? _____

What activities lessen symptoms? _____

Is condition worse or better during certain times of day? _____

Is this condition interfering with Work? _____Sleep? _____Daily routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other doctors seen for this condition? _____

Any medications or surgeries for this condition? _____

Any home remedies? _____

About Your Care

What results do you hope to achieve from our office?

____ **Relief Care-** Relieve/reduce symptoms and increase comfort.

____ **Corrective Care-** Move beyond pain relief to correct the problem, improve function and allow your body to stabilize.

____ **Wellness Care** – Maintain the care you've received and allow your body to continue to rebuild and become healthier.

Wellness Care focuses on prevention, wellness and overall good health.

Health Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

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 disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. This may be via mail, telephone or email.

May we leave a message either on voicemail or with the person answering the call? Yes / No

Name of patient _____

Signature of patient or guardian _____ **Date** _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various physical therapy modalities, and if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor.

I have had the opportunity to discuss with the doctor and/or other office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned chiropractic procedures. I intend this consent form to remain valid throughout my course of treatment in this office.

_____	_____	_____
Print patient's name	Signature of patient (or parent/guardian)	Date