

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please fill out these forms COMPLETELY in ink. If you have any questions or concerns do not hesitate to ask for assistance. We will be happy to help.

CHIROPRACTIC CARE CONSENT AND WAIVER

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy, on me (or for the patient I am legally responsible) by the doctor of chiropractic employed by Sport and Spine Chiropractic, LLC or serving as back up for Sport and Spine Chiropractic, LLC in any office or facility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including by not limited to, fractures, disc injuries, stroke, dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all the risks and complications, and I 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 interest.

I have read, or have been read to me, the above consent. I have also had the opportunity to ask a question about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition in which I seek treatment.

ADMISSION INFORMATION

Welcome! Thank you for selecting Sport and Spine Chiropractic, LLC as your provider for physical therapy and chiropractic treatment. Patient and Provider expectations will be defined during the admissions process. A successful relationship is dependent upon sharing and participation in meeting the goals as outlined by the doctor.

PATIENT RIGHTS AND RESPONSIBILITIES

You the patient have the right to:

- ❖ Be treated with dignity and respect
- ❖ Confidentiality
- ❖ Participate in the assessment and care planning process
- ❖ Be provided service in a timely manner
- ❖ Be notified in advance of types of treatment and frequency of treatment being provided
- ❖ Be notified of any changes in your plan of care and treatment
- ❖ Receive an explanation of the billing process and an explanation of charges
- ❖ Express grievance without fear of reprisal or discrimination
- ❖ Refuse or discontinue

You the patient are responsible for:

- ❖ Providing information when services are rendered
- ❖ Following the treatment plan as outlined by the doctor
- ❖ Notifying practice when you will not be available for treatment or will be late for treatment
- ❖ Rescheduling any missed treatment in order to keep on schedule as outlined in your treatment plan
- ❖ Performing all the rehab exercises including the prescribed home care program as outlined by the doctor
- ❖ Notifying the practice of any change in your condition, physician orders, attending physician, or attorney
- ❖ Notifying the practice of any incident involving the staff or equipment
- ❖ Payment of all co-payment or deductible applicable per the insurance plan of your choice

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Sport & Spine Chiropractic, LLC 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 Sport & Spine Chiropractic, LLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I hereby authorize Dr. Hugunin to treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I agree that I am responsible for all bills incurred at this office.

Signature _____ Date _____

HIPPA AUTHORIZATION SECTION

I, _____ hereby authorize the use and disclosure of the following health information that pertains to me for the purposes of payment, authorization, and referrals. Reference to the entire HIPPA law is posted next to the reception counter for full review. I understand that if I am unable to locate the poster, I will ask for direction to it. I authorize the following persons to make and receive these disclosures of my health information:

1. Sport and Spine Chiropractic, LLC
2. Primary Care Physician and other Treating Physicians
3. Attorney
4. Health Insurance Company/Health Insurance Commissioner

I understand that information disclosed to the authorization may be disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Sport & Spine Chiropractic, LLC. I further understand that any such revocation does not apply to the extent that persons authorized to use and disclose my health information have already acted in reliance on the authorization. I understand that this authorization will not expire as use of the personal health information is being used for payment purposes. I understand that I am under no obligation to sign this authorization. I further understand that my ability to receive treatment, my eligibility for benefits will not depend on whether I sign this authorization or not. I understand that I have the right to inspect and to obtain a copy and any information disclosed pursuant to this authorization. I understand that Sport & Spine Chiropractic, LLC will receive compensation for the uses and disclosures that I have authorized.

Signature _____ Date _____