CONFIDENTIAL PATIENT INFORMATION

DATE ___/___/___

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME_____ DATE OF BIRTH ___/___/____ AGE ___ Male☐ Female☐

ADDRESS_____ APT#_____ SSN _____ - ____ - _____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (_____)_____

ALTERNATE PHONE (CELL): (_____)_____ EMAIL ADDRESS: _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE ____ ZIP _____

WORK PH. # (_____)_____ EXT._____ DATE SYMPTOMS BEGAN: ____/____/____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____PHONE_____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐

TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐

I WILL BE PAYING TODAY BY CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____

INSURED'S EMPLOYER SAME AS ABOVE ☐ _____

INSURED'S SSN SAME AS ABOVE ☐ SSN _____ - ____ - _____ INSURED'S DOB SAME AS ABOVE ☐ ____/____/____

PRIMARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

****

SECONDARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident 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. 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. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

FIRST CHOICE CHIROPRACTIC! INC.
JASON D. HADDOCK, D.C.
223 Cox Creek Pkwy.
Florence, AL 35630
phone (256) 766-1987 fax (256) 766-1987

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I,_____, hereby state that by signing this Consent, I acknowledge and agree as follows;

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice is available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
   a) a postcard mailed to me at the address provided by me; and
   b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice may choose not to treat me.

First Choice Chiropractic
223 Cox Creek Parkway
Florence, AL 35630
Office (256) 766-1987
Fax (256) 766-1924

Dr Jason D. Haddock

OFFICE POLICY

Patient Name_____Date of Birth_____

Waiting for insurance payment is a courtesy and may be withdrawn at any time. This clinic does not promise that any insurance company will pay, nor does this clinic promise that an insurance company will or should pay the fees as charged. The clinic will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement.
This is the patient's obligation.

Full payment for services rendered is due at the end of each visit. If for any reason this request can not be met, arrangements must be made in advance before seeing the doctor

On all insurances, the deductible must be met in the beginning unless prior arrangements are made in advance.

Past due accounts will be charged a service charge of 1 ½ % per month

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to the patient above will be immediately due and payable.

I (we) the undersigned, hereby agree to pay all amounts and charges hereafter incurred by myself and members of my family for services rendered by First Choice Chiropractic. Failure to make payments when requested is basis for legal action and the below signed agrees to pay all costs of collection including a reasonable attorney's fees and hereby waives their rights of exemption under the law of the State of Alabama or another state.

I have read and understand the office policy.

Patients Signature_____Date_____

Spouse (Guardian if Minor)_____Date_____

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)	Signature of Individual
Signature of Legal Representative*	Relationship

Date Signed ____/____/____ Witnesss _____

*Attorney-In-Fact, Guardian, Parent if a minor

FIRST CHOICE CHIROPRACTIC
223 COX CREEK PARKWAY
FLORENCE, AL 35630
(256) 766-1987 FAX (256) 766-1924
Dr. Jason D. Haddock
Chiropractic Physician

REQUEST FOR RECORDS, X-RAYS AND REPORTS

I, _____, hereby authorize_____
To use and/or disclose to First Choice Chiropractic the following specific protected health information:_____
_____

Date of Service: _____

I understand that this authorization is valid until ___/___/____ or until my release from care.

I understand that the authorizer may revoke this authorization in writing at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for X-ray examination.

I am or could be pregnant. Yes or No
My last menstrual period began on: _____

I do hereby authorize the Doctor to examine and treat any condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays negatives will remain the property of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Authorizing Request:_____

Witness:_____ Date:_____