Patient Name: _____ DOB: _____

1) Insurance Assignment and Financial Responsibility

Our office is pleased to accept your Insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim and assist you in every way we can.

1. Your insurance contract is between you and your insurance company. You are fully responsible to know and understand your insurance benefits before care, and are fully responsible for any amount not paid by your insurance.
2. Since by taking your insurance assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
3. Your insurance company should pay on claims filed within 30 days: if they require additional paperwork filled out by you (accident/injury information, co-ordination of benefits or any other forms), you are obligated to fill out any and all forms sent to you and return them within 10 days.

We will apply any insurance payments toward the cost of your care and the remaining balance will be your responsibility. Please be aware that as Providers of Health Care, we are governed both by law and industry standards including insurance company requirements to keep adequate records. Forms used in our office provide history, subjective and objective communication and other information used to ascertain "medical necessity" of care. Therefore it is necessary for "Intake Forms", (forms filled out by you), to be done both initially and periodically throughout your treatment.

- **ASSIGNMENT**

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. I also authorize this clinic to release any information pertinent to my case to any insurance company adjustor and attorneys involved in this case; and hereby release this clinic of any consequence thereof.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

Meaning of Assignment: For purposes of this agreement, accepting assignment of the **Medicare Part B** payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. We shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

A photocopy of this assignment shall be considered as effective and valid as the original.

- **FINANCIAL RESPONSIBILITY**

I agree to be financially responsible for all charges incurred at this clinic including, but not limited to my insurance deductible, co-payments, co-insurances and services rejected by my insurance company and non-covered services.

2) Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below.

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

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible 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, and is in my best interest. I also acknowledge that I may receive phone calls, text messages or emails regarding appointments, coordination of benefits, and/or billing statements from this office.

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3) Healthcare Operations

I acknowledge that "Notice of Privacy Practices & Policies and Procedures Manual" will be provided to me upon my request. I may request the manual from any Janis Chiropractic personnel.

I understand I have the right to review Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractic. This notice of Privacy Practices also describes my rights and Janis Chiropractic duties with respect to my protected health information.

Janis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

4) IF REPRESENTATIVE, LEGAL GUARDIANSHIP and/or CONSENT for MINOR

*As parent or legal guardian, I authorize the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below and/or his staff to render any necessary treatments including, but not limited to: examinations, x-rays and any other treatment necessary.

5) HIPAA PRIVACY STATEMENT

I authorize the following person(s) (**List Names Below**) access to my medical and insurance (billing) information, this person also has my permission to schedule and cancel my appointments at Janis Chiropractic. (I.e. spouse, significant other, parents, children, etc.) This authorization allows for this to be done in person, by phone, electronically or by mail. This authorization for Hipaa Privacy may be revoked at any time in writing, dated and signed by patient.

1. _____ 3. _____

2. _____ 4. _____

PATIENT NAME: _____ Date of Birth: _____
(PRINT LEGAL PATIENT NAME)

By signing below, I acknowledge and understand the above information listed 1-5. I have also had an opportunity to ask questions about its content, and intend this consent form to cover the entire course of treatment for my condition(s) at Janis Chiropractic & Wellness Center (Dr. Alex Janis, PLLC)

_____ _____/_____/_____
Signature of Patient, *Parent (if minor), Legal Guardian, or Representative (Power of Attorney) **Date of signature**

_____
Please list Relationship to patient (if other than self)

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