OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

   []Initial Exam., []X-rays, ([]Cerv-AP& Latrl, []Cerv-APOM, []Cerv-Flex/Ext, []Cerv-Obliques, R&L, []Thoracic-AP &Latrl, []Lumbar-AP &Latrl,[]Shoulder-Int/Ext Rotation, []Knee-AP &Lateral,
   []Wrist/Hand-AP, Latrl &Oblq, []Ankle/Foot-AP, Latrl &Oblq), []Electric Muscle Stim []Heat/Cold Thera

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

X-RAY CONSENT FORM

Patient Name ____ Date _____________

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment. Digital copies are provided, upon request, to our patients for $8 and to non-patients for $85.

By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Patients Signature _______________________________________ Date _____________

THIS PORTION FOR WOMEN ONLY:

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 am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant. Yes No

I could be pregnant. Yes No

I am late with my menstrual period. Yes No

I am taking contraceptives. Yes No

I have had a tubal ligation. Yes No

I have had a hysterectomy. Yes No

I have irregular menstrual periods. Yes No

My last menstrual period began on ____

With full understanding of the above, and believing that I am currently not as risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature ____ Date: ____________

THIS FORM IS FOR EVERYONE; PLEASE SEE TOP PORTION.

ACCIDENT HISTORY

Date of Accident ____/_____/_____ Time of Accident _____ ☐ AM ☐ PM
Where?____
Details of the Accident ____
____
____
Make/Model/Year of your Vehicle___________________________ Make/Model/Year other vehicle______________________
Driver or Passenger? __________ ☐Lap belt ☐Shoulder Belt ☐Both ☐No Seat Belt Worn Passengers? Y N
Number___
Were police at the accident scene? ☐Yes ☐No Is there an accident report? ☐Yes ☐No Road: ☐Wet ☐Dry
Did you go to the hospital? ☐ Yes ☐ No By ambulance? ☐ Yes ☐ No
List exams and tests you received at the hospital
____
____
Other physicians you've seen for this
accident____
____
Were you ☐Aware of the approaching collision prior to impact, or did it ☐Catch you totally by surprise?
Any cuts or bruises from this accident?
____
Did you lose consciousness (black out) upon impact? ☐Yes ☐No How long were you out? _______________________
Did you experience a flash of light/explosion in your head, or "see stars"? ☐Yes ☐No
Was your vehicle stopped at the time of impact? ☐Yes ☐No
Was your vehicle ☐Slowing down ☐Gaining speed ☐Traveling at a steady rate
What was the speed of your vehicle? _____________ Was your foot on the brake? ☐Yes ☐No
What did your vehicle impact ☐Another Vehicle ☐Other Explain ____
During impact were you facing ☐Right ☐Left ☐Forward
Did any body parts strike something in the car? ____
Where is the headrest in relation to your head? Approximately _____ inches ☐Above ☐Below ☐ Not Sure
Did airbags deploy? ☐Yes ☐No ☐ Not Sure

WORK HISTORY

At the time of this injury did you have a job? ☐ Yes ☐ No
Employer/Address ____ Occupation
____
Did you miss any work because of your injuries? ☐ Yes ☐ No From:____/____/____ To:____/____/____
Explain your job requirements, including positions, postures & hours: ____
____

INSURANCE INFORMATION

Who owns the vehicle involved in the
accident____
Insurance Company ____ Policy Number
____
Claim Number _____________________________ Adjuster Name
____
Were you riding a bicycle, pedestrian, or a passenger, when the accident happened? _____(If yes, please fill out car insurance info above).

Name of Attorney: ____ Phone: ____________________

I have completed this form to the best of my knowledge and all information above is true in fact and substance. Furthermore, I understand that I am responsible for updating my account if information changes, and for any claim that may be denied if the information I have provided is untrue.

____ _________/_________/_________
Patient Signature Date

____ _________/_________/_________
Authorized Provider Representative Printed Date

Assignment of Insurance Benefits, Release & Demand

I the undersigned patient/insured knowingly, voluntarily and intentionally assign all the rights and benefits of my automobile insurance, also known as Personal Injury Protection (P.I.P.) and medical payments policy of insurance to **Select Health and Wellness**. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim of common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patients name on the check.

The insurer is directed by the provider and undersigned to NOT issue any checks or drafts in partial settlement of a claim that contain or accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to amount payable under the insurance policy or contract. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced payment in full. The provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned herby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing any dispute, or intent to examination under oath. The provider or the provider's attorney is expressly authorized to appear at any patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

Lien: I authorize my attorney (where applicable) to pay the provider directly such sums as may be due for medical service rendered me both by reason of this accident, or any other bills, that are due to the office, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien of my case to this provider against any and all proceeds of my settlement, judgement or verdict which may be paid to my attorney or myself, as a result of the injuries for which I have been treated. I fully understand that I am directly and fully responsible to Select Health and Wellness for all medical bills submitted for services rendered and that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by Select Health and Wellness and to request any statements or examinations under oath the patient provided to any insurer.

Release of information: I hereby authorize Select Health and Wellness to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from the insurer all EOBs for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer, obtain all medical records from any other provider or insurer.

Demand: Demand is herby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and insurance coverage declaration sheet to provider within 15 days.

Certification: I certify that: I have read and agree to the above; have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by treatment or service; I agree to the provider's prices for medical services, treatment and supplies are reasonable and customary.

I have read and understand the above document.

______________________________	______________________________	__________
Patient Name	Patient or Guardian Signature	Date

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: March 26, 2013

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 Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 904-425-9060.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Taylor Fritz at 904-425-9060.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

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 and understand the Privacy Protection Act.

____

Print Name

____

Signature

____

Date

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options):

Name: ____ Phone Number: _____________________

Name: ____ Phone Number: _____________________

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name: ____ Phone Number: _____________________

Name: ____ Phone Number: _____________________

3. Please print the address of where you would like your billing statements/or correspondence from our office to be mailed if ***other than your home.*** **(Confidential Communications)**

____

____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "**CONFIDENTIA**L" Yes_______ No________

Select Health and Wellness
1605 County Rd 220 Suite 165
Fleming Island, FL 32003
904.425.9060
SelectHealthandWellness.com

Select
Health and Wellness

1605 County Road 220, Unit 165,
Fleming Island, FL 32003
904.425.9060
904.425.9061

Confidential Patient Information

Date: ____________________

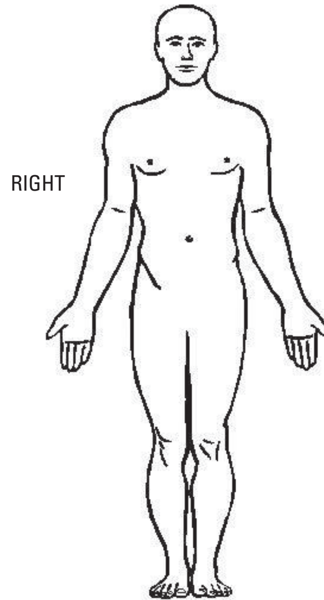
First Name ______ Last Name ______ Initial ______

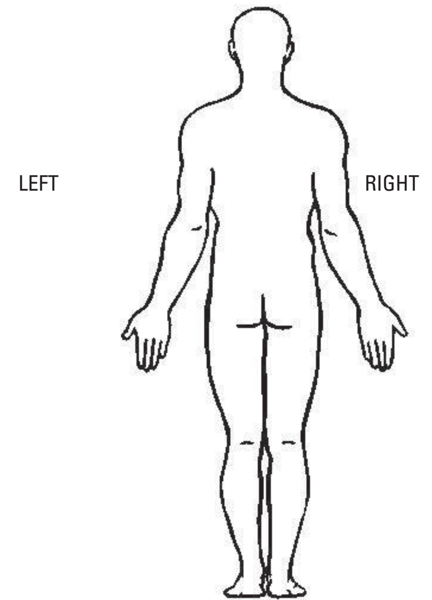
Major Complaint Information

What is your major complaint(s)? ____________________

When did this symptom(s) begin? ____________________

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from I to I 0 indicating the extent of the pain. (I being minor, I0 being severe)





Pain Index

B Burning
S Sharp/Stabbing

For example: if you are experiencing moderate/ severe burning pain in bock of your neck, you should note a "B8" on the neck of the illustration.

If this is an injury, describe what happened:

____

____

____

____

On a scale of 1-10, how do you feel now?
(1 being best, 10 being the worst)

1	2	3	4	5	6	7	8	9	10
Best									**Worst**

Have you experienced these symptoms before? ❑ Yes ❑ No When? ____________________

These symptoms developed from? ❑ Auto Accident ❑ Work-Related Other? ____________________

Have you reported this to your: insurance company ❑ Yes ❑ No Employer? ❑ Yes ❑ No

What aggravates this condition? ____________________

What decreases the symptoms/pain? ____________________

Have you seen a doctor for this condition? ❑ Yes ❑ No Doctor's Name: ____________________

Date consulted: ____________________ Diagnosis: ____________________

Does this condition interfere with your sleep? ❑ Yes ❑ No If so, how many times do you wake up in pain per night? ________

In what position do you sleep? ❑ Back ❑ Side ❑ Stomach Do you sleep with a pillow? ❑ Yes ❑ No How many? ________

Does heat affect the pain? ❑ Yes ❑ No How? ____________________

Does cold affect the pain? ❑ Yes ❑ No How? ____________________

Do you wear a heel lift? ❑ Yes ❑ No If so, which side? ❑ Right ❑ Left

Does it cause pain to cough, grunt or sneeze? ❑ Yes ❑ No If so, where? ____________________

Check those activities below during which you experience difficulty or pain:

____ Lying on back	____ Gripping	____ Pulling	____ Reaching	____ Kneeling
____ Getting in/out of car	____ Pushing	____ Bending forward	____ Bending back-ward	____ Walking
____ Sleeping	____ Sitting over one hour	____ Sneezing	____ Coughing	Other: ____________
____ Stooping	____ Climbing	____ Turning over in bed	____ Lying flat on stomach	____________
____ Standing for periods over one hour	____ Lying on side with knees bent	____ Dressing self	____ Sexual activity	____________

Fill out the next three sections as they apply to you

Headaches

Do you have a family history of headaches? ❑ Yes ❑ No Do you get headaches? ❑ Yes ❑ No Frequency ____________

Do you experience the following along with your headaches: Pain or cracking in your jaw? ❑ Yes ❑ No

Abnormal blood pressure? ❑ Yes ❑ No ❑ High ❑ Low Nausea, Vomiting or Visual disturbances? ❑ Yes ❑ No

When was your last eye exam by a doctor? ❑ 1-6 months ❑ 6-12 months ❑ 1-2 years ❑ over 2 years Results: ____________

____

Lower Back Pain

Do you ever experience ripping or tearing sensations in your back? ❑ Yes ❑ No No If so, where? ____________

Does pain radiate to the abdomen? ❑ Yes ❑ No Do you ever have impairment of bowel or urinary function? ❑ Yes ❑ No

Explain: ____

Neck Pain

If you have a neck injury, does it effect: (Check all that apply) ❑ hearing ❑ vision ❑ balance ❑ cause ringing in your ears

Do you hear grating sounds? ❑ Yes ❑ No Do you feel pressure or pain behind your eyes? ❑ Yes ❑ No

Do you feel ripping or tearing? ❑ Yes ❑ No Where? ____________

Do you have difficulty lifting or turning your head? ❑ Yes ❑ No If so, in which direction? ❑ Right ❑ Left ❑ Up ❑ Down

If female, are you pregnant? ❑ Yes ❑ No ❑ Not Sure If yes, what is your due date: ____________

List all medications you are taking now, including over the counter medication: ____________

____

Are you allergic to any medications: ❑ Yes ❑ No ❑ Not Sure Please List: ____________

____

Have you ever had any surgeries or hospitalizations? ❑ Yes ❑ No Please List:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:

Have you been x-rayed in the last 12 months? ❑ Yes ❑ No When ____________

Have you ever been seen by a chiropractor before? ❑ Yes ❑ No Please List:

Name of chiropractor:	Dates:	Name of chiropractor:	Dates:

Do you have a family physician? ❑ Yes ❑ No Name of physician: ____________ Phone: ____________

____

Address City State Zip

Check those activities below during which you experience difficulty or pain:

- ❑ Headache
- ❑ Loss of Concentration
- ❑ Eyes Sensitive to Light
- ❑ Memory Loss
- ❑ Heavy Feeling of Head
- ❑ Dizziness
- ❑ Ringing in Ears
- ❑ Loss of Balance
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Pain Behind Eyes
- ❑ Fainting
- ❑ Palpitation
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Neck Motion Restricted
- ❑ Upper Back Pain/Stiffness
- ❑ Mid Back Pain/Stiffness
- ❑ Lower Back Pain/Stiffness
- ❑ Right/Left Shoulder Pain
- ❑ Right/Left Arm Pain
- ❑ Right/Left Leg Pain
- ❑ Pins & Needles Arms/Legs
- ❑ Vision Problems
- ❑ Sinus Trouble
- ❑ Nervousness
- ❑ Chest Pain
- ❑ Shortness of breath
- ❑ Loss of Consciousness
- ❑ Irritable
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia
- ❑ Fatigue
- ❑ Flushed Face
- ❑ Excess Perspiration
- ❑ Digestive Trouble
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Cold Hands
- ❑ Cold Feet
- ❑ Jaw Pain
- ❑ Cancer
- ❑ Hypertension
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Allergies (Please List) ____________________
- ❑ Anemia
- ❑ Heart Disease
- ❑ Arthritis
- ❑ HIV (Aids)
- ❑ Other (Please List) ____________________

Please Specify location:

- ❑ Numbness ________
- ❑ Swelling ________
- ❑ Cuts ________
- ❑ Bleeding ________
- ❑ Broken Bones ________
- ❑ Bruising ________

Do you have, or have you ever had, any diseases or medical problems not listed? ❑ Yes ❑ No If so, please list: ____________________

Any additional information you would like the doctor to know about before beginning care at Select Health and Wellness? ____________________

Emergency Contact

Name: ____________________ Relation: ____________________

Home Phone: ____________________ Work Phone: ____________________

Address City State Zip

Insurance Information

Insurance Company: ____________________ Phone# ____________________

Address City State Zip

Insured's Name: ____________________ Insured's SS# ____________________ Group# ____________________

Insured's Birth Date: ____________________ Insured's Employer: ____________________

Personal Information

Address City State Zip

Home Phone: ____________________ Work Phone: ____________________

Mobile Phone: ____________________ Email: ____________________

Social Security#: ____________________ Birth Date: ____________________ Age: ________ Sex: ❑ M ❑ F

Drivers License# : ____________________ Marital Status: ❑ S ❑ M ❑ D ❑ W

Spouses Name: ____________________ # Children: ________

Occupation: ____________________ Employers' Name: ____________________

Work Address City State Zip

How were you referred to Select Health and Wellness? ____________________ Do you have an Attorney? ❑ Yes ❑ No

Name: ____________________ Phone#: ____________________

Address City State Zip

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself I clearly understand and agree that all services rendered 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 professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Select Health and Wellness to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Select Health and Wellness responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment xrays an: taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at Select Health and Wellness.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, VoL 37 No. 2,June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

______________________________ _______________
Patient Signature Date

______________________________ _______________
Parent/Legal Guardian Signature Date

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:

____
Second Address City State Zip

Phone: ______________________________

Check months at this address: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec