Patient Information & Consent Form

Insurance Claims:

I request the payment of authorized benefits be made directly to the office of Complete Chiropractic Rehab Center. This signature allows Complete Chiropractic Rehab Center to submit my claims to Medicare or any other health insurance carrier directly for payment. I authorize release of any medical information to process claims.

Patient Signature: _____ Date: _____

I accept responsibility for the remaining balance after payment of such benefits from my insurance carrier. Complete Chiropractic Rehab Center accepts Usual and Customary payment. The patient is responsible or any outstanding balance remaining after Usual and Customary is adjusted for the balance.

Patient Signature: _____ Date: _____

Appointment Reminders:

This office may use your name, address, phone number and clinical records to contact you with appointment reminders, public relations and all other health related issues.

Patient Signature: _____ Date: _____

Healthcare Information Authorization and Privacy Rules:

In general, HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of the protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information is made by alternative means. If you would like more information on HIPAA, our office will supply this information for you.

Patient Signature: _____ Date: _____

Out-of-Network Consent:

I wish to be a participant in the chiropractic and rehabilitation out-of-network treatment program offered by Complete Chiropractic Rehab Center. I have been informed and will participate in the plan of care as diagnosed by the out-of-network chiropractor. I also have been informed of the procedures and methods of treatment that will be administered to me, and I fully understand what is required of me as a patient. I verify that my participation is fully voluntary; no coercion of any sort has been used to obtain my participation. I may withdraw from treatment at any time.

Patient Signature: _____ Date: _____