

Patient Care Guidelines

General Care • Auto Collision
Personal Injury • Worker's Comp



HIPAA
Protected Health Information
Authorized Access Only

Date _____

Patient/Clinic ID # _____

Patient Name _____

Date of Birth _____

Social Security # _____

Other Information _____

I, _____ hereby agree to be treated by
Patient Name
(Dr./Clinic) _____ for the diagnosis
explained to me on _____ for the condition and/or injuries that began on
Today's Date

Date

I hereby further agree to maintain and cooperate with the above named Doctor and/or Clinic staff recommendations for Chiropractic Care for Rehabilitation of the Spinal Condition (VSC) diagnosed from my exam or the injuries or incident sustained on _____
Date

In the event of excessive missed appointments without notification or authorization to the above named Doctor or Clinic, it will be assumed that I have reached a point of stabilization and/or symptomatic relief and that I am dismissing myself from care. Therefore, my Doctor or Clinic can then notify my employer, insurance agent, insurance carriers, and lawyers that I am no longer being treated and I have returned to work without restrictions and or limitations.

I hereby further agree upon such notification by this office to my employer and/or attorney and/or insurance carriers, that I will pay upon demand, all bills incurred for my treatment to date.

I clearly understand this "office policy" and that all past, present and future bills incurred at this Clinic are my responsibility for payment. I hereby agree to pay all bills upon demand and my doctor will not be involved in any 3rd Party disputes. Billing for all Clinical and rehabilitation services is done as a courtesy and I understand there is no guarantee of third party payment.

Patient Signature *Date*

Witness Signature *Date*

Doctor/Staff Signature *Date*