TERMS OF ACCEPTANCE: PATIENT: _____ DOB: _____

Authorization for Care: I authorize Touch of Life Chiropractic to complete a consultation, examination and render treatment they deem necessary for my care. To the best of my knowledge, I ◯ AM / ◯ AM NOT pregnant at this time. I understand that x-rays may be ordered when medically necessary, and only if no limitations that would be contraindicative of an x-ray evaluation are present. I will disclose any changes in my condition(s) to my provider prior to additional treatment.

Consent for Chiropractic Services: I have been made aware of the following:

1. A "Chiropractic Adjustment" may be performed manually, with a table or drop mechanism, or with an instrument to the vertebra of the spine and/or associated structures, often resulting in an audible popping or clicking sound.
2. "Supportive Therapies" may be incorporated and applied by the Doctor or Staff under the Doctor's supervision.
3. On occasion, temporary soreness and/or stiffness may occur; less frequently, aggravation of the presenting symptoms or new symptoms; rarely, bruising, swelling, separation or fracture; extremely rarely, nerve or vascular injury may occur in conjunction with the application of a Chiropractic Adjustment.
4. The Doctor makes no guarantee of a positive outcome from treatment.

Assignment of Benefits: By signing below, I acknowledge and assign my health and/or accidental insurance benefits to be paid directly to Touch of Life Chiropractic. I understand that submitting my insurance is a courtesy, and does not guarantee payment or negate my responsibilities of payment for services rendered. I understand that a portion of the care provided under this agreement may not be covered by my insurance and that payments paid by myself are to be applied to any deductible, coinsurance, copays, and/or non-covered services provided by my healthcare provider.

CMS-1500 Claim Form: I acknowledge and agree that by signing this form, Box 12 and Box 13 will state "Signature on File" on the CMS-1500 health insurance Claim Form. Box 12 reads: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 reads: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorized payment of medical benefits to the undersigned physician or supplier for services described below."

Notice of Privacy Practices: I authorize the office to contact me for financial or care related issues in the following ways: PHONE – home, work, or cell phone, with messages left on personal numbers; EMAIL – provided in intake forms; MAIL – home address provided. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this office is obliged to supply a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of my personal health information and my rights as a patient. I acknowledge that this document is available for me to read at any time.

Changes in Status: I agree to notify the office within 48 hours should there be any changes in my healthcare coverage, or should a legal personal injury incur due to a work accident or a motor vehicle accident. In the event that benefits become available due to a worker's compensation or personal injury claim, I understand that this agreement will be temporarily suspended while I am being treated for any accident related injuries, and that a new exam and/or Care Plan may be required.

Missed Appointments: I understand that I must make up any missed appointments within the time period recommended by my healthcare provider. Should I schedule any vacation during my Care Plan, I will notify my healthcare provider 5 days prior to my vacation and my Care Plan will be extended. Minimal vacation time for extension is one week. Maximum vacation time for extension is 1 month.

Communication: I understand that I should communicate any requests in writing either, directly with the office located at: 1300 W. Koenig Lane, Ste. 180, Austin, TX 78756, or via email to touchoflifeaustin@gmail.com.

Release of Information: I consent to the release of my personal health records to the following:

Medical Provider: _____

Medical Provider: _____

Personal Contact: _____

I understand that I have the right to receive a copy of this authorization and my personal records at any time upon written request.

Complete Agreement: This agreement is non-transferable and constitutes both my Care Plan agreement and Financial Agreement between myself and Touch of Life Chiropractic. No other facilities or healthcare providers are covered by this agreement. By signing below, I certify that all information provided to the office in the INTAKE forms is true and accurate to the best of my knowledge.

Patient or Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____