INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Physicians, Chiropractors, Osteopaths, and Physiotherapists using manual manipulation are required to advise their patients:

- With neck problems, there have been rare incidents of injury to the vertebral artery during the course of treatment. These have caused stroke like symptoms that are usually temporary in nature. These chances of this happening are approximately 2 in 1 million treatments.
- With neck and back problems, there have been rare incidents of rib separation or fracture, disk injury, and more commonly pain, bruising, swelling, and aggravation of symptoms.

In order to minimize risk appropriate test will be prompted.

I hereby give consent to the chiropractic treatment as indicated needed and explained to me. If during the course of treatment an unforeseen condition or complication arises, I further give consent to such additional diagnostic procedures and treatment as my be necessary by sound and prudent chiropractors.

I acknowledge that no guarantee or warranty has been made to me that the results will be to my complete satisfaction.

I have read the above, understand and consent to treatment.

_____ _____

Patient Signature Date

(If patient is a minor see below)

_____ _____

Print Guardian Name Guardian Signature

3930 Louetta Rd., Suite A, Spring, TX, 77388 PHONE: (281) 528-9177 FAX (281) 528-9545

RISK ASSOCIATED WITH PHYSIOTHERAPY MODALITIES

Flexion / Distraction Therapy

- Aggravation of present condition

Hot Packs

- 1st & 2nd degree burn
- Hemorrhage

Ice

- Skin reaction

Interferential Therapy

- Skin reaction
- Spread of unknown infection
- Spread of unknown cancer
- Small risk of electric shock
- Interference with blood pressure if used in cervical (neck) region

Intersegmental Traction

- Aggravation of present condition

Trigger Point & Myofascial Therapy

- Bruising
- Release of emboli

Ultrasound

- Periosteal burns
- Skin reaction
- Spread of unknown infection
- Spread of unknown cancer

Patient Signature

Date

3930 Louetta Rd., Suite A, Spring, TX, 77388 PHONE: (281) 528-9177 FAX (281) 528-9545

CLINIC FINANCIAL POLICY

PARTICIPATING INSURANCE PATIENTS:

This clinic is a participating provider with the following insurances (these are subject to change at any time and may include other healthcare plans): Aetna, ASH /Cigna, Blue Cross Blue Shield, Humana, Triwest / VA Referral Only, UHC, and UMR.

It is the responsibility of the patient to call the insurance company and verify insurance coverage for chiropractic care at this office. All benefits quoted are a general outline and are not a guarantee of payment. As a provider, the clinic cannot hold a patient responsible for unusual and customary provider reductions. Depending upon your specific plan you may be responsible for a percentage, copay and/or deductible at each visit. Our office does require copays due at the time of services. We also request if you have a deductible, a payment each visit is necessary to offset your deductible charge.

INIDIVIDUAL INSURANCE (OUT OF NETWORK):

Your insurance policy is an agreement between you and your insurance company and not between your insurance company and this chiropractic office. It is the responsibility of the patient to call the insurance company and verify insurance coverage for chiropractic care at this office. All benefit quotes are a general outline and are not a guarantee of payment. As a courtesy to our patients, the clinic will submit all eligible charges to the insurance company; however, it is to be understood that all rendered are 100% the patient's responsibility and a payment at each visit is required.

SELF-PAY:

The patient's payment is to be made in full following our clinics self-pay fee schedule and will be due on the day of services at Hancock Family Chiropractic.

The below signature acknowledges that I have read the above statement and understand the policy and financial responsibility. I also authorize direct assignment of payment for all professional services to be paid by my insurance company to Hancock Family Chiropractic located at 3930 Louetta Rd. Suite A, Spring, TX, 77388 and realize that any outstanding balance will be promptly paid by me.

Also, I further agree to the release of any and all medical records to my health insurance, if requested, in order to insure prompt payment on the medical claim.

_____ _____

Patient Signature Date

_____

Print Name

3930 Louetta Rd., Suite A, Spring, TX, 77388 PHONE: (281) 528-9177 FAX (281) 528-9545

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO TREAT & RELEASE MEDICAL RECORDS

Assignment of Benefits

I authorize the direct payment to Hancock Family Chiropractic, PLLC of any sum I owe or hereafter owe Hancock Family Chiropractic, PLLC by my attorney out of the proceeds of any settlement of my case. Or my insurance company is obligated to make payment to me or you based in whole or in part of services rendered. I permit this office to endorse any co-issued remittance for the conveyance of credit to my account.

In the event that any insurance company is obligated by contractual agreement to make payment to me, or to you for the charges made for your services, refuses to make payment upon demand of you. I hereby assign any such company to authorize you to prosecute such action either in my name as you see fit and further authorizer you to compromise, settle and otherwise resolve said claim as you see fit.

I understand that the payment of charges incurred are due at the time of service unless other financial agreement has been made prior to treatment. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Authorization to Release Medical Records

I hereby authorize any representative of Hancock Family Chiropractic, PLLC to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, billing company / associate / advocate, collection agency, or insurance advocate / adjuster in order to process any claims for reimbursement of charges incurred by me.

Authorization to Treat

I, the undersigned hereby authorize this clinic (and whomever may be designated as assistant(s), partner, or administrator such examinations and treatment as they deem necessary.

I understand that as part of my healthcare that this facility originates and maintains my health records describing personal and confidential information that may include, but not limited by my mental health, symptoms, examinations, test results, diagnosis, treatment impairment ratings, and insurance information.

I have read and fully understand the above-mentioned assignment of benefits, authorization to release medical records, and authorization to treat. A photocopy of this assignment shall be valid and have the same effects as the original.

_____

Print Name

_____ _____

Patient Signature / Parent of Guardian (if applicable) Date

_____ _____

Witness By Date

MISSED APPOINTMENT POLICY

We want to thank you for choosing our office as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and / or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24- hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last moment everyone loses – you, the doctor, and other patients that would like to have utilized your appointment.

Our office will charge a $20 fee for broken / missed or cancelled under 24 hours appointments; please realize the importance it is to keep your reserved appointments. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

_____ _____

Patient Signature / Guardian of Minor (if applicable) Date

PATIENT HEALTH INFORMATION CONSENT FORM (HIPAA NOTICE)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. We have provided a detailed account of our policies and procedures concerning the privacy of your Patient Health Information (PHI), we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this portion of the document. I have read and understand how my Patient Health Information (PHI) will be used and I agree to the policies and procedures.

_____ _____

Patient Signature / Guardian of Minor (if applicable) Date

HANCOCK FAMILY Chiropractic

RELEASE FORM: Allowable contact by Email /Text /Phone & Use of Testimonial

Being a Healthcare Provider, one of our top priorities is to protect you and your private health information (PHI). We go to great lengths to ensure that your PHI is well protected. At Hancock Family Chiropractic, PLLC, we are passionate about clear communication and transparency.

As you know, we live in an ever increasingly technological age that exchanges information via cell phones, social media and internet-based activity. This advanced ability to communicate has created wonderful opportunities to create a global community, but also opens possibilities for misuse of these options. We want to communicate with you in a way that is convenient and comfortable for YOU! Please let us know you preferences below:

Authorization for Release of Information

We are requesting your permission for Hancock Family Chiropractic/ Dr. Shane J. Hancock to communicate with you in the following ways:

1) **I authorize Hancock Family Chiropractic, PLLC to call/fax and/or leave voice or text messages that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc. -at the following phone number/numbers I provide on intake forms.**
_____ **Initial here for your consent**

2) **I authorize Hancock Family Chiropractic, PLLC to utilize the following email addresses to send messages that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc.; Email addresses I provided on intake forms.**
_____ **Initial here for your consent 0**

TESTIMONIALS

3) **I choose to give a patient testimonial** for the purpose of, but not limited to, the publication or promotion of my thoughts, feelings, and experiences, as they relate to Hancock Family Chiropractic, PLLC, Dr. Hancock and /or staff.

I understand my testimonial/review, made on behalf of Hancock Family Chiropractic, PLLC, may be used in connection with publicizing and promoting Hancock Family Chiropractic, PLLC. I authorize Hancock Family Chiropractic, PLLC to use my name, brief biographical information, and the Testimonial/Review, as well as any photographs of me. The effective date is the first day of any services provided by Hancock Family Chiropractic, PLLC, Dr. Hancock, and /or staff.

I hereby irrevocably authorize Hancock Family Chiropractic, PLLC to copy, exhibit, publish or distribute pictures, video and/or my written Testimonial/Review for purposes of publicizing Hancock Family Chiropractic, PLLC programs or for any other lawful purpose. These statements, photos or videos may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against Hancock Family Chiropractic, PLLC for the use of the statement, testimonials/reviews, video or pictorial representations of me. In addition, I waive any right to inspect or approve the finished product, including written copy or edited video wherein my likeness or my testimonial appears. I hereby hold harmless and release Hancock Family Chiropractic, PLLC from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons, acting on my behalf or on behalf of my estate, have or may have by reason of this authorization.
_____ **Initial here for your consent**

I have read the information above and authorized the initial sections.

Signature: _____

Printed Name: _____

Email: _____

Address: _____

City, State, Zip: _____

Cell phone: _____ Date: _____