ADVANTAGE CHIROPRACTIC

1460 KELLY RD. SUITE 102

APEX, NC 27502

919-728-7774 PHONE

919-728-6114 FAX

[www.advantagechironc.com](http://www.advantagechironc.com)

FINANCIAL AGREEMENT

YOUR INSURANCE COVERAGE/PLAN IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY AND ***THIS***OFFICE. WE ***CANNOT*** *BE* CERTAIN IF YOUR INSURANCE COVERS CHIROPRACTIC, ALTHOUGH MANY POLICIES OFTEN PROVIDE SOME COVERAGE. THE AMOUNT THEY PAY VARIES FROM ONE POLICY TO ANOTHER. WHEN POSSIBLE WE WILL CALL TO VERIFY BENEFITS ON YOUR INSURANCE: HOWEVER, ***THE BENEFITS QUOTED TO US BY YOUR INSURANCE COMPANY ARE NOT A GUARANTEE OF PAYMENT. WE VERIFY YOUR INSURANCE AS A COURTESY TO YOU.*** YOU, AS THE PATIENT, MAY CALL YOUR INSURANCE COMPANY AS WELL. IT IS TO BE UNDERSTOOD AND AGREED THAT ANY SERVICES RENDERED MAY BE CHARGED TO YOU DIRECTLY AND YOU ARE PERSONALLY RESPONSIBLE FOR PAYMENTS OF ANY NON-COVERED SERVICES, DEDUCTIBLES, CO-INSURANCE AND/OR CO-PAYS.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENT.

|  |
| --- |
| **SIGNATURE DATE** |

|  |
| --- |
| **WITNESS DATE** |

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**NOTICE OF PRIVACY PRACTICE**

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Advantage Chiropractic**

**1460 Kelly Rd. Suite 102**

**Apex, NC 27502**

**919-728-7774**

**PREGANANCY WARNING AND CONSENT TO X-RAY**

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_I AM A MALE PATIENT. THIS DOES NOT APPLY TO ME, BUT I DO CONSENT FOR X-RAYS.**

**I UNDERSTAND THAT IF I AM PREGNANT AND HAVE X-RAYS TAKEN WHICH EXPOSE MY LOWER TORSE TO RADIATION, IT IS POSSIBLE TO INJURE THE FETUS.**

**I HAVE BEEN ADVISED THAT THE 10 DAYS FOLLOWING 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:**

**YES NO I DON’T KNOW**

|  |  |  |  |
| --- | --- | --- | --- |
| **I AM PREGNANT** |  |  |  |
| **I COULD BE PREGNANT** |  |  |  |
| **I AM LATE WITH MY MENSTRUAL PERIOD** |  |  |  |
| **I AM TAKING ORAL CONTRACEPTIVES** |  |  |  |
| **I HAVE AN IUD** |  |  |  |
| **I HAVE HAD A TUBAL LIGATION** |  |  |  |
| **I HAVE HAD A HYSTERECTOMY** |  |  |  |
| **I HAVE IRREGULAR MENSTRUAL PERIODS** |  |  |  |

**MY LAST MENSTRUAL PERIOD BEGAN ON\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WITH FULL UNDERSTANDING OF THE ABOVE, AND BELIEVING THAT I AM NOT CURRENTLY AT RISK, I WISH TO HAVE AN X-RAY EXAMINATION PERFORMED.**

**PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WITNESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**MISSED APPOINTMENT POLICY**

**EFFECTIVE July 1, 2021**

We want to thank you for choosing us 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 appointments especially for you. Therefore, we request at least 24 hours 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 minute, everyone loses – you, the doctor, and other patients that would like to have utilized your appointment time.

**Our office will allow one (1) missed appointment without being charged. Including the second (2nd) missed appointment, there will be a $20.00 charge added to your patient account for each missed appointment.**

Thank you for your consideration of our policy and for the opportunity to be your chiropractic office of choice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date



**PATIENT STATUS AT**

**TIME OF CONSENT:**

( ) OF LEGAL AGE

( ) ORIENTED x3

( ) COHERENT/LUCID

( ) PROFICIENT ENGLISH

( ) ASSISTED BY INTERPRETER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) MEDICATED, BUT UNIMPAIRED

( ) DENIES USE OFALCOHOL OR

RECREATIONAL DRUGS PRIOR TO

CONSENT

( ) UNABLE TO GIVE LEGAL CONSENT

( ) CONSENT VIA LEGAL GUARDIAN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s questions (if any) and responses are as follows:**

**Comments:**

I certify that this form accurately reflects the patient’s status during the informed consent process.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine and exercises. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective form of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

***Soreness****: It is common to experience muscle soreness during treatment.*

***Uncomfortableness****: Temporary symptoms (dizziness, nausea) can occur, but are rare .*

***Fractures/Joint Injury****: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.*

***Stroke****: Strokes from chiropractic adjustments are rare.*

***Burns****: Some therapies used generate heat and may, in rare cases, cause burns.*

**Treatment results**: I understand there are benefits associated w/treatment including decreased pain, improved mobility and function, and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

**Alternative Treatments Available**: Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor’s choosing and provide my informed consent for treatment.

**I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**PATIENT NAME: PATIENT FILE #:**

**INFORMED CONSENT FOR TREATMENT**