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ABOUT YOU

Today's Date:	/	1		File #:	
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Birthdate://	Ag	e:	SS#:		
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Home Phone #: ()				
Work Phone #: (•				
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E-mail Address:					
Referred By:					
Employer:			How	Long?	
Employer's Address:				_	
CITY		STA	TÉ.		ZIP
Occupation:					
Status: Minor Single	Marrie	d 🗅 Divor	rced 🗆 Se	parated 🗆 W	idowed
Spouse's Name:					
Do you have children?) Yes	□ No	How ma	any?	
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Primary Insurance		
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Person ultimately respon	nsible	for account	
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Drivers License #:			
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(if offered at this office).

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Cell Phone #: ()	
Who is your Medical Doctor? Medical Doctor's Phone #: (

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rst Impressic rms, Inc. 1-800-99FORMS FORM # 2MCA2 Copy.

☐ Spouse

Date

and understand it is my responsibility to inform this office of any changes to the information I have provided.

☐ Parent or Guardian

Signature

Q Adult Patient

©2004

Initials

Comments

Cons	ent Form
Reed	Chiropractic

Patient Name:	
Chart #	

I hereby request and consent to the performance of chiropractic adjustments and other procedures including but not limited to various forms of manual therapy, physiological therapeutics, traction, modalities, exercises, physical therapy, diagnostic x rays or range of motion tests on myself (or the patient listed below for whom I am legally responsible) by the doctor of chiropractic, as an employee of Reed Chiropractic Associates and/or other licensed doctors of chiropractic now or in the future at this clinic.

I understand and have been informed that in the practice of chiropractic medicine there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations or sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications that could occur. I wish to rely upon the doctor to exercise prudent judgment during the course of any procedures which the doctor feels at the time, with the information given, is in my best interest.

I have read or had read to me the above consent. I have also been given the opportunity to ask questions about this consent. By signing below, I agree to the above named procedures. I intend this consent form to remain valid for the entire course of my treatment for my present condition or any future conditions for which I seek treatment. I understand that I have the right to revoke this consent in writing at any time for any and all future procedures with the understanding that any such revocation shall not apply to the extant that Reed Chiropractic Associates has already taken action in reliance on this consent.

Patient Signature:	(Guardian's s	signature if the patient is under 18)
Date: Witn	ess Signature:	
Consent for Chiropractic X rays		
Patient Name:	Chart #	Date
During your examination, the doctor ma should be made aware that these x rays rays patient, our office requires the patient	may be required in order to administer	treatment. In order to perform x rays on
By signing below I agree and understand and I give permission for all such diagno		der to properly diagnose my condition
I UNDERSTAND THAT IF I REFUSI REFUSE ANY TREATMENT	E TO HAVE X RAYS, THE DOCTO	OR RESERVES THE RIGHT TO
Patient Signature:	(Guardian's sig	nature if the patient is under 18)
Date:		
Females Only – I confirm that I am no	ot pregnant. <u>Patient Signature</u> :	

Reed Chiropractic Associates, P.C. Dr. Jason T. Reed, DC CCEP HIPPA Declaration

The Practice:

- * Is required by federal law to maintain your privacy and to provide you with *this* privacy notice the practice's legal duties and privacy practices with respect to your personal health information.
- * Under the Privacy Rule, the practice may be required by state law to grant greater access or maintain greater restrictions on the use or release of your personal health information than that which is provided for under federal law.
- * Is required to abide by the terms of the privacy notice
- * Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for all of your personal health information that is maintained.
- * Will distribute any revised privacy notice to you prior to its implementation
- * Will not retaliate against you in any way for filing a complaint

This notice is in effect as of April 6th 2009

The Patient:

By signing my name below, I acknowledge receipt of this privacy notice and declare my understanding and agreement to its terms.

terms.	
Patient or Guardian's signature:	Date:
	Email and Message Authorization
Associates, their employees and Di	(patient), do hereby give consent to Reed Chiropractic r. Jason T. Reed, DC to use my email address for possible future and that I can be removed from the e-mail list at any time by providing a
Associates, its employees or with the following indi	(patient), do hereby give consent to Reed Chiropractic and Dr. Jason T. Reed, DC to leave detailed messages on my voicemail viduals. I also give permission for my accounting information, insurance al records to be disclosed and discussed with the following individuals.
_	(Guardians' signature if the patient is under 18)
Date:	
Witness Signature:	Date:

Reed Chiropractic Financial Policies

Thank you for choosing Reed Chiropractic as part of your health care team. We are committed to providing the best possible care for you. In order to achieve this goal, we need your help in understanding our financial policies. Please understand that proper payment of your bills is considered part of your treatment plan. Please read and initial after each section.

It is the policy of Reed Chiropractic to collect payment for any deductibles, co pays, co insurance and non covered charges at the time of service. We accept cash, check, VISA, Mastercard, Discover and Care Credit as methods of payment. If you need to discuss alternative payment arrangements, you must do so BEFORE you receive care. There is a \$35 collection charge on any returned checks. Initial:
Health Insurance : Reed Chiropractic is happy to file your medical insurance for all services rendered. It is important that you understand that your health insurance is an agreement between you and your insurance company. Our office is not responsible for what your insurance will or will not pay. It is your responsibility to know and understand the Chiropractic benefits listed in your policy as well as any limitations that may apply. It is your responsibility to provide our office with the most up to date copies of both primary and/or secondary insurance cards before services are rendered. As a courtesy our office will attempt to contact your insurance company to verify benefits but this in NOT A GUARANTEE OF COVERAGE. Our office will do its best to estimate as closely as possible what your portion of the bill will be. The final amount due can only be known after your insurance company has processed the claim. If that amount is different from the good faith estimate, you will be responsible for the additional cost. If there is an overage, the amount will be held in your account and used as a credit toward future visit. There will be no refund. Initial:
Non Covered Expenses: Our office is committed to providing the best treatment for our patients and we charge usual and customary charges for Chiropractic care. The goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, not on what your insurance coverage may be. You are responsible for payment of charges your insurance company reduces or denies. Any claim that your insurance company refuses to process is your responsibility. Initial:
Collections: Any account that is over 90 days past due is subject to being turned over to a collection agency. You will receive notice in the mail with fair warning before this occurs. If you have provided a credit card number to keep on file, the amount will be charged to that card before the account goes to collections, Reed Chiropractic is not responsible for any mail that you do not receive due to a bad address that was not updated by you to our office. There will be additional fees added by the collection agency that will be your responsibility as well. You will not receive treatment again until the bill is paid in full. Initial:
Special Forms: The completion of FMLA, disability or other special request forms is a time consuming process and requires up to 14 days to complete. There is a \$30 charge for the completion of such forms and that amount is not covered by any medical insurance. Initial:
Medical Records Requests: If we referred you to another physician for consultation or continued care we will forward your records to that physician directly if necessary at no cost. If you request copies of your records for any other reason, there is \$1.00 per page charge. If you need your x rays burned on a disk, there is a \$7 charge. There is a 3 day turn around time on either request. Initial:
Missed Appointment Charge: Attending your scheduled appointments is crucial to successful treatment of your condition. If you need to cancel or reschedule an appointment, please allow us the courtesy of a 24 hour notice so that we may schedule someone else in need at that time. If you fail to give notice or do not show up there will be charged a \$30 charge. This charge is not covered by any insurance company. Initial

Authorization for the Release of Medical Records

Patient Name:	Date of Birth:		
I hereby request and authorize:			
Reed Chiropractic Associates, P.C. Jason T. Reed, DC CCEP 1531 Lindsay Ln S Athens, AL 35613 Phone # 256-206-9722 Fax # 256-206-9725			
To Disclose Information to:	To receive information from:		
Provider			
Address			
City/State/Zip			
Phone #	Fax #		
Information to be disclosed include copies of:			
Entire medical record	X Ray Films & Reports		
MRI Images & reports	CT Scans & reports		
Daily chart notes	Progress Reports		
Other, specify:			
This authorization will be effective until such time that understand that the cancellation will have no effect on cancellation notice. A copy of the authorization is as variable.	any information released or obtained prior to receiving the		
Signature of Patient or Guardian:	Date:		

Notice to recipient of information: This information has been disclosed to you from confidential records which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the express written consent of the patient or legal representative.