**JP NJNY Associates**

**DBA: North Dover Chiropractic Wellness Centre**

*New Patient Personal Information*

Name_____

Address_____

City_____ State_____Zip Code_____

Telephone Number_____

Birthday_____

Age_____Sex_____

Referred By_____

Employer_____ Full Time / Part Time /Retired / Unemployed/Disabled

Married_____Spouse Name_____Single / Divorced / Separated

Health Insurance Name_____

Address_____

ID Number_____Group Number_____

Drivers License Number_____

*Which answer best describes your own current ideas and values toward health?*

[ ] **Treatment only** – I only consult a doctor when I have problems/symptoms and discontinue care as soon as the symptoms leave.

[ ] **Early Detection** – In addition to symptom relief, I see doctors occasionally to detect problems early before they become serious

[ ] **Prevention** – I am conscious of my health, diet, exercise and actively pursue these because I feel and perform better.

[ ] **Wellness** – I actively inform myself about true health and I am concerned with the long-term effects of things on my health.

*Terms Of Acceptance*

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the patient and our office to be working for the same objective. Chiropractic has only one goal.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustment of the spine.

Health: Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnosis or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services for another health care provider. Regardless of what the disease is called, we do not offer to treat it, Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's *innate wisdom*. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements. All questions regarding Dr. Nicole's objective pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

---

Date:_____

Consent to evaluate and adjust a minor/child:

I,_____, being the parent or legal guardian of _____ have read fully and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Insurance billing Procedures and Policies

All first visit charges ar epayable when services rendered. Each patient must make their co-payment and any unsatisfied deductible at the time of services.

The fee paid for treatment x – rays is for analysis only. The film itself is property of this office. Once films are used for treatment purposes, they cannot be release Copies can be made if necessary.

Method of payment you plan to use to take care of today's charges? Cash / Check/ Credit Card

As a courtesy to our patients, we will bill your insurance company for the treatment rendered, We must first verify your coverage. A patient assignment release must be signed in order for this office to bill your insurance company. Accepting assignment does not mean we accept as full payment whatever the insurance company pays. Most insurance companies call for the patient to pay a deductible and/or a portion (co-pay) of the bill. Regardless of what is stated in the insurance policy, the patient portion is whatever the insurance company does not pay.

It is the patient's responsibility to keep his/her account current. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself, not between the doctor and the insurance company. The insurance company must legally answer to the patient and is under no legal obligation to respond to this office. It is the patient's responsibility to make sure that any correspondence form the insurance carrier be given to us to make copies for our records. Failure to notify this office of any insurance correspondence may jeopardize your claim and account balance with this office. Furthermore, I understand JP NJNY Associates

(DBA: North Dover Chiropractic Wellness Centre) will prepare nay necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to JP NJNY Associates (DBA: North Dover Chiropractic Wellness Centre) will be credited to my account up receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I understand I am responsible for the full amount rendered if payment by my insurance company is denied, or if my account becomes delinquent. If I am no longer under care at JP NJNY Associates (DBA: North Dover Chiropractic Wellness Centre), I understand that my remaining balance is to be paid in full. Should my account become due in excess of 90 days from billing, I acknowledge a monthly interest fee of 1.5% may be added to amount due for the an APR of 18% . Should my account be turned over for collection, I understand that I am liable for all attorney fees which amount not to less than one third of the total amount due, plus other collection and/or court costs. I acknowledge I will be charged a one-time service fee of $50.00, in addition to the monthly interest fee of 1.5%.

In addition, a fee is added of $30.00 for each missed appointments and no call.

We appreciate your cooperation.

Patient Name_____

Patient Signature_____

Date_____

*Signature On File*

-I AUTHOREIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.

-I AUTHORIE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.

-I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.

-I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FORM INSURANCE CO'S.

-I AUTHORIZE PAYMENT DIRECT TO MY DOCTOR.

-I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORGINAL.

Signature_____

Date_____

# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

| | | |
|---|---|---|
| May we phone, email, or send a text to you to confirm appointments? | YES | NO |
| May we leave a message on your answering machine at home or on your cell phone? | YES | NO |
| May we discuss your medical condition with any member of your family? | YES | NO |

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____