PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES

Our office uses sign-in sheets, travel cards, and provides care in "open-door" adjusting environment. Adjustments are done in an open adjusting area as a result patients are in sight of each other and some on going routine details of care may be overheard by other patients and/or staff. This environment is used for on going care and is not the environment for taking patients histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity.

In addition, your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Patient's Signature _____ Date _____

Privacy Policy Received
Patient's Signature _____ Date _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by McGuire Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of McGuire Chiropractic. I understand that Dr. McGuire may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above-stated purposes.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. McGuire Chiropractic is not required to agree to the restrictions that I may request however, if McGuire Chiropractic agrees to a restriction that I request, the restriction is binding to McGuire Chiropractic and Dr. McGuire.

I understand I have a right to review McGuire Chiropractic's Notice of Privacy Practices (which has been provided to me) prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of McGuire Chiropractic. The Notice of Privacy Practices for McGuire Chiropractic is also provided on request at the front desk of this practice. Notice of Privacy Practices also describes my rights and McGuire Chiropractic's duties with respect to my protected health information.

McGuire Chiropractic has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling McGuire Chiropractic's office and request a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have a right to revoke this consent in writing, at any time, except to the extent that McGuire Chiropractic or Dr. McGuire has taken reliance on this consent.

Patient/Guardian Signature _____ Date _____

PAYMENT/INSURANCE AGREEMENT

In consideration of your undertaking and care of me, I agree to the following:

If for any reason my account is delinquent for over 30 days, I hereby authorize McGuire Chiropractic to collect the full amount from my credit card account listed below, along with a 3% office fee (ie: $55 balance will result in a charge of $56.65 total charge to my credit card).

-OR-

In the event my insurance company forwards payment for your service directly to me (specifically Blue Cross and Blue Shield Members) I will be responsible to render such payments to McGuire Chiropractic, along with the Explanation of Benefits that was provided to me, within 10 days.

If for any reason I do not issue McGuire Chiropractic the original payment or a personal payment within 10 days, I hereby acknowledge my account will be in a delinquent status.

If I choose not to provide my credit card information to avoid such matters, I hereby acknowledge that my information will be forwarded to an outsourced collection agency, which will affect my credit. I understand that McGuire Chiropractic will take aforementioned action if I do not contact them to arrange a payment within 30 days of my delinquent status.

Name _____

Address _____

Credit Card: Master Card Visa Discover

Card Number _____

Ex. Date _____ Security Code _____

Patient's Signature _____ Date _____