Champion Chiropractic
4532 E. Lone Mountain Rd. STE 107
Cave Creek, AZ 85331
480-595-0001

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name:_____ **Date of Birth:**_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of my insurance benefits to Champion Chiropractic or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay, co-insurance, deductible amount and/or balance due that Champion Chiropractic is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Champion Chiropractic or physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION

I certify that I have received and read a copy of the Champion Chiropractic Patient Information Privacy Policy. I hereby authorize Champion Chiropractic or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, E-MAIL, OR TEXT

I certify that I understand the privacy risks of mail, phone calls, e-mails, and texts. I hereby authorize Champion Chiropractic representative or my physician to mail, call, e-mail, or text me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Champion Chiropractic to that effect in writing.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing, and treatment as directed by my Champion Chiropractic physician or his or her designee.

MISSED APPOINTMENT FEE

I acknowledge that I will be charged a $30 Missed Appointment Fee if I miss an appointment or do not cancel or reschedule my appointment within 4 hours of scheduled appointment time.

Patient Signature:_____ **Date:**_____

Guarantor Signature:_____ **Date:**_____
(If different from patient/or minor)

Guarantor Name: PLEASE PRINT_____

SOCIAL MEDIA

I consent to having my first name only, image, and testimonial used on public social media (i.e. Facebook).

Patient Signature:_____ **Date:**_____