Hayden Chiropractic PLLC

Dr. Jason W. Hayden
522 W. Main St. 361-782-0798 Tel.
Edna, TX 77957 361-782-0799 Fax
haydenchiropractic@gmail.com

Patient Name: ____ Sex: □ M □ F

Mailing Address: ______________________________ City: _______________ State: _______ Zip:__________

SS# _______-_______-________ Date of Birth: ___________________ Age: ______ DL#: _________________

Email Address: ____

Hm Phone: _____________________ Cell Phone: _______________________ Wk Phone: _________________

Employer/School: _____________________________________ Occupation: ____________________________

□ Married □ Widowed □ Single □ Divorced □ Minor

Referred By: ____

Emergency Contact: Name: ______________________________ Number: ____________________________

Responsible Party

Name of person responsible for this account: ____

Relationship to patient: ____ Phone: (_____)_____________

Address: ________________________________ City: __________________ State: _____ Zip Code: _________

Patient Condition

Reason for Visit: ____

In order to help us understand your pain/problem, please describe your symptoms and how they occurred:

____

____

If you have insurance: *(please present card to front desk)*

Insurance Co: __________________________________ ID#:__________________________Group#:___________
Subscribers Name: ______________________________________ Relationship: Self / Spouse / Child / Dependent
DOB: _______/_______/_____________ SS#_______-______-___________
Subscribers Address: ____
Secondary Insurance Coverage: □ YES □ NO

Assignment and Release

I certify that I, and/or my dependent(s) have insurance with the above said insurance company, and assign directly to Dr. Jason W. Hayden, D.C. with Hayden
Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether
or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named Dr. may use my health care information and may disclose such information to the above named Insurance Company and their agents for the
purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
Signature of Patient or Representative:____
Date: _________________________________ Relationship to Patient: _______________________________

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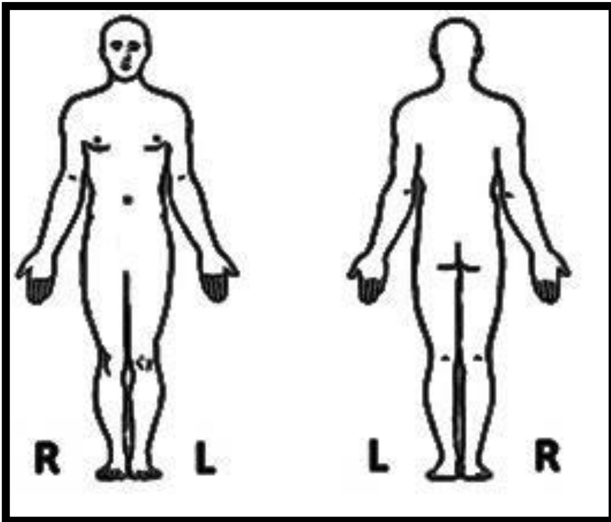
Date: ____/____/_______ **Patient Name: ____**

Complaints:
Please mark on the drawing below the areas causing you pain



Please explain your complaints or add any additional comments:

____

____

____

When did your symptoms occur?

____

Do you feel:

Better Same Worse

Intensity:

Minimal Slight Mild Mild-Moderate Moderate Moderate-Severe Severe

Frequency:

Intermittent Occasional Frequent Constant

Pain Scale: Circle the number that best describes your pain.

None -0 1 2 3 4 5 6 7 8 9 10 -Severe

Symptoms you feel are:

PAIN BURNING STIFFNESS TINGLING

NUMBNESS SHARP PAIN OTHER

Consent to Treat: By signing below, I do by hereby consent to receive the treatment that Dr. Hayden has recommended for today.

Patient Signature: ____

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Waiver of Liability

Dear Patient,

This form is used for all patients who wish to receive healthcare services from Hayden Chiropractic, and have their insurance billed for those services. The rules that govern payment for services are unique to each insurance payer, and some services received may not be covered by your specific insurance policy. The fact that your insurance carrier may or may not pay for a particular service, does not mean that you should not receive it. There is a good reason why your doctor has recommended this treatment. Your insurance company may add or change coverage policies at will, and this could affect the payment for your services, at Hayden Chiropractic.

Under your health plan, you are financially responsible for any co-payments, co-insurance and deductibles for "covered services". You are also financially responsible for all non-covered services, including any service determined by your insurance company to be: "not covered", "not medically necessary", "not authorized", "patient share", "patient responsibility", "maintenance", "not supported by documentation", or otherwise deemed a non-payable benefit. This includes a determination of non-payment based on a post-service claim review basis, also known as a retroactive denial.

Your signature on this form acknowledges that you agree to bear full financial responsibility, for all services provided at Hayden Chiropractic.

By my signature below, I agree to be fully financially responsible for payment of all services rendered

____
PRINT the Patient Name

____
PRINT the Responsible Party/Legal Guardian's Name.

____ ____________________
SIGNATURE of Patient/Responsible Party/Legal Guardian's Date

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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by **Hayden Chiropractic** and/or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the Doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Doctor to exercise judgment during the course of the procedure which he feels are in my best interests at the time, based upon the facts then known.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by Dr. Hayden. I intend this consent form to cover the entire course of treatment for my present condition(s), and for any condition(s) for which I seek treatment at this facility.

____ ____
Print Patient's Name Print Representative's Name if Applicable

____ ______/_______/____________
Signature of Patient (or Representative) Date

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.
* You may request restrictions on your disclosures.
* You may request to view changes to your records.
* In the future, we may contact you for appointment reminders, announcements and to inform you about our Practice.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
* *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
* *Obtain payment from third party payers.*
* *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

____ ______/_______/____________
Signature of Patient or Representative Date

Relationship to Patient (If applicable): ____