Mellon Chiropractic Clinic

Patient Registration

Today's Date: ___________________

Name: ____ Sex **M** **F**

Address: ____

City____________________ State__________________ Zip Code___________________

Cell Number: _________________________

E-mail Address: ________________________________ Date of birth: ___________________

Social Security: ________________________________

If referred by whom? ________________________________

Emergency Contact Name and Number: ____

Reason for visit and location of Pain: ____

____

Insurance Information

Policy Holders Name: _______________________________________Birthdate: _____________________

Member ID: ____ Group Number: ___________________

Relationship to policy holder: ______________________

Address if different than yours: ____

Medications | **Medication Allergies**

_________________________ | __________________________________

_________________________ | __________________________________

_________________________ | __________________________________

_________________________ | __________________________________

_________________________ ___________________

Patient's Signature **Date**

Fee Sheet Billed to Insurance Company

Service	Fee
Exam **(99201)**	**$90.00**
Re-Examination **(99211)**	**$40.00**
Manipulations 1-2 Regions **(98940)**	**$45.00**
Manipulations 3-4 Regions **(98941)**	**$55.00**
Manipulations 5-6 Regions **(98942)**	**$70.00**
Extremity Manipulations **(98943)**	**$35.00**
Interferential Stim **(97014, G0283)**	**$30.00**
Therapeutic Procedure **(97110)**	**$40.00**
Mechanical Traction **(97012)**	**$30.00**
Ultrasound **(97035)**	**$35.00**
Deep Tissue Laser individual charge	**$50.00**
Deep Tissue Laser Package charge	**$250.00-$350.00**

*Fees subject to change upon doctor's evaluation.

This is the amount billed to your insurance company for payment by them with a possible balance due to you.

Patient Acknowledgment

The undersigned patient hereby understands and agrees that he/she is solely and exclusively responsible for any charges or fees incurred during treatments at Mellon Chiropractic Clinic. The undersigned patient further acknowledges and agrees that any amounts **not paid** by the insurer in part or in total are the sole and exclusive responsibility of the patient.

Patient ______________________________ **Date** ________________________

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Informed Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on **myself** or
______________________________, by the licensed doctor of chiropractic engaged in practice in this clinic.

I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read the above information and I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

______________________________ ______________________________

Patient's Name (Print) **Patient's Signature**

_______________ ______________________________

Date **Relationship or authority if not signed by patient**

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Mellon Chiropractic Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received or been offered a copy of the Notice of Patient Privacy Policy. _________ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request

By my signature below I give my permission to use and disclose my health information.

____ ____________
Patient or Legally Authorized Individual Signature Date

____ ____________
Print Patient's Full Name Time

____ ____________
Witness Signature Date

Listed below I give my permission to disclose my health information to the following person/people.

____

____

____

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