Intake for New Patients — Consents

Accuracy of Information *Required*

I certify that the above medical information is correct to my knowledge. Yes No

Privacy and Sharing of Information *Required*

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

initials *Required* _____

No-show *Required*

After the third no show you will be billed for the full cost of treatment for adjustments and exams. For massages you will be billed for every missed appointment.

initials *Required* _____

Payment *Required*

I authorize payment of any medical benefits from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I know or hereafter I owe this office by my attorney, out of the proceeds of any settlement of my case and by

any insurance company contractually obligated to make payment to me or you based on the charges submitted for products and services rendered.

Authorize Payment to Office _____

Authorize Payment for Self-reimbursement by insurance _____

Insurance Policy *Required*

I have been made aware of the office insurance policy. We are out of network for all insurers. Estamos fuera de la red de todas las compañías de seguros. हम सभी बीमा कंपनियों के लिए नेटवर्क से बाहर हैं

- This means we do not contract with any insurance company for their rates and there will be reduced coverage amounts/higher deductibles for you.
- Patients are personally responsible for payment of services.

We will do our best to verify your insurance in a timely matter as a courtesy to you. If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release medical information necessary to process this claim. If you suspend or terminate your care at any time, your portion of all charges is immediately due and payable to this office. You are ultimately responsible for payment regardless of insurance coverage.

initials *Required* _____

Name _____ Date_____
Relationship _____