Ashland Chiropractic Center, Inc.
Robert E. Bachelder, DC, DABCO
1182 Twp. Rd. 1175, Ashland, OH 44805
(419) 289-8592 (p) ~ (419) 289-5583 (f)

Confidential Patient Information

Patients Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS#: _____ Email: _____

Employer: _____ Occupation: _____

Marital Status: M S W D Spouses Name: _____

Is your present condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

If the patient is less than 18 years of age, or is 18 but still in high school, complete the following:

Parent/Legal Guardian Name: _____

Relationship to patient: _____ DOB: _____

Address: _____ City, Zip: _____

Phone: _____ Alternate Phone Number: _____

I, the undersigned, having legal custody/legal guardianship of _____ (a minor), authorize the following person(s) as agents to consent to any x-ray, examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor. It is understood this authorization is given in advance of any specific diagnosis or treatment being required, but is given to provide authority to the below listed agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirement of this authorization, may, in the exercise of his/her best judgement, deem advisable.

This authorization shall remain effective until the minor patient's 18th birthday: _____, unless revoked in writing and delivered to Ashland Chiropractic Center, Inc.

Parent/Legal Guardian Signature: _____ Date: _____

Agent 1) _____ Relationship: _____

Agent 2) _____ Relationship: _____

Agent 3) _____ Relationship: _____

Patient/Legal Guardian Signature: _____ Date: _____

Office use only - Reviewed (date/initials): _____ _____ _____ _____

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Patient Name: _____ Date: _____

Terms of Acceptance

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make known, or to learn through healthcare procedures, what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating healthcare service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regimen. I understand that if I am accepted as a patient by a physician at Ashland Chiropractic Center, Inc., I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. _____ (initials)

Missed Appointments:

A $25.00 fee may be charged for appointments that are not canceled 24 hours prior to the scheduled visit. In addition, , patients with repeated missed appointments, or no call/no show appointments, may be dismissed from the practice. _____ (initials)

Financial Policy:

It is our office policy that payment in full is due at the time of service. Additionally, we require that each patient pay their copay, coinsurance and/or their deductible at each visit. You may be billed for any outstanding balance(s) not covered by applicable insurance(s). In order to ensure the best billing practice, please provide your insurance information to the front office staff *before* each visit. Failure to do so may result in our inability to submit your claim(s). We do not participate with all medical insurance carriers plans. Accepting your insurance does not place all or any financial responsibilities on this practice. You will be held accountable for any unpaid balances. Our service(s) may not be covered by your insurance carrier. Please remember that you are fully responsible for all charges incurred; our verification of your insurance benefits is an estimation of coverage and not a guarantee of payment, or a transfer of liability. Please do not assume that you will not have a balance if you have coverage or insurance from more than one insurance carrier. You agree that in order for us to service our account(s) and/or collect any amount(s) you may owe, we (or any collection agency employed by us) may contact you by telephone at any and/or all telephone numbers associated with your account, including wireless telephone numbers, which could result in charges to you. Furthermore, you may also receive text messages and/or e-mails, using any wireless telephone number and/or e-mail address provided by you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Your account will be considered in default if not paid in full within 90 days. Any account may be placed with a collection agency; if your account is placed with a collection agency and legal action is initiated, you will be responsible for any amount due including, but not limited to, interest, fees/charges and/or expenses incidental to the principal amount prior to a judgement being rendered against you. _____ (initials)

Communications:

In the event that we need to communicate your healthcare information, to whom may we do so? (Name and phone #):

No one: _____ Spouse: _____

Child: _____ Other: _____

May we leave messages regarding your personal healthcare information on any answering device, answering machine or voicemail? _____
May we contact you via e-mail? _____

Acknowledgement:

I have read and fully understand Ashland Chiropractic Center, Inc.'s Term of Acceptance. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon my request, I will be given a copy or either/both forms.

Patient/Legal Guardian Signature: _____ Date: _____