OKC WELLNESS CLINICS
NORTH/SOUTH OKC/ MOORE
TERMS OF ACCEPTANCE

Patient Name:_______________________________ D.O.B.______________________ Date:_____________________

Before the office begins any health care operations, please read and sign this form stating that you understand the information below. By refusing to sign, the doctor reserves the right to refuse to care.

AUTHORIZATION: “PREGNANCY” By signing below, you state to the best of your knowledge there is no pregnancy, confirmed or suspected, at this time. To the best of your knowledge, there are no limitations that would be contradicted for an X-ray evaluation.

You consent to the taking of X-rays if it is determined through the examination to be needed.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below, you have acknowledged that you are fully responsible for all services rendered. You further acknowledge understanding that your health and accident insurance information policies are an arrangement between you and your carrier and that you may be required to pay some or all of the fees charged to your account.

You hereby assign benefits directly to this office/provider by your third-party payer, e.g., insurance company, attorney, etc. You agree that this is a non-rescindable agreement and that failure to fulfill this obligation will be considered a breach of contract between you and this office.

Finance Fee: As the responsible party, I have been advised that once payments on this account are past due for over thirty days, I may be responsible for a finance fee of 22% to be compounded annually. In addition, past due accounts may be turned over to collections. The responsible party agrees to reimburse and pay OK Wellness/Chiropractic Arts Center for any expenses, attorney fees, and/or any costs related to the collection of past due accounts.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below, you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state “Signature on File”. Box 12 reads as follows: “PATIENT’S OR AUTHORIZING PERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts the assignment below.” Box 13 reads as follows: “INSURED OR AUTHORIZED PERSON’S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.”

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. For this reason, only you can authorize the release of this information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office-related matters in the following manner: phone (work, home, mobile,) email, and regular mail. Messages may be left on an answering device/voicemail or with the person answering your phone (work, home, mobile). In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), updated September 23, 2013, this office will supply you with a copy of the office privacy policies and procedure upon request. It outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

By signing below, you acknowledge that you have been offered a copy of this document.

ACKNOWLEDGMENT OF TREATMENT PLAN: By signing below, I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGMENT: By signing below, you have acknowledged that you understand and agree with the policies and procedures outlined in this TERMS OF ACCEPTANCE form. By signing below, you certify that all information given to the office on the INTAK forms is true and accurate to the best of your knowledge.

Patient Signature______________________________ Date:________________________

Witness Signature_____________________________

OKC WELLNESS

CONSENT FOR X-RAY & CHIROPRACTIC SERVICES

BY SIGNING, I HEREBY AUTHORIZE OKC WELLNESS CLINICS AND WHOMEVER THE CLINICIAN DESIGNATES AS HIS/HER ASSISTANT(S) TO TAKE X-RAYS OF MYSELF AND SAID MINOR.

CONSENT TO X-RAY- PREGNANCY RELEASE

DATE OF ONSET PATIENTS LAST MENSTRUAL PERIOD (LMP):______________________

I HEREBY RELEASE OKC WELLNESS CLINICS FROM ANY AND ALL LIABILITY

By signing this, I have been made aware of the following:

1. The process of delivering a "Chiropractic Adjustment (Manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and or associated structures (legs, arms, ribs, and other extremities), often resulting in an audible pop or clicking sound.
2. In conjunction with the Chiropractic Adjustment, "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision, incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, cold, or acupuncture.
3. That on occasion, some temporary soreness and/or stiffness may occur, less frequently aggravation of presenting symptoms or the initiation of new symptoms, rarely bruising, swelling, even more rarely separation/fracture, and extremely rare, nerve or vascular injury may occur in conjunction with the process of a chiropractic adjustment.
4. The chiropractor has made no guarantee of a positive outcome of treatment.

By signing:

1. I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and/or staff under the direction of the chiropractor(s) involved in my case.
2. I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and/or staff under the direction and supervision of the office chiropractor(s) involved in my case.

Patient Signature________________________________ Date:____________________

Witness Signature________________________________