



PATIENT INTAKE FORM

Patient Information

Full Name: _____ Date: _____
 First MI Last

Address: _____ City: _____ Zip: _____

Age: _____ Birth Date: _____ Gender: _____

Best Phone Number: _____ Alternate Number: _____

I prefer to receive appointment reminders by: _____ Phone Call / Text Message

Email Address: _____

Emergency Contact: _____ Contact Number: _____

Whom may we thank for referring you today? _____

Patient Consent for Treatment, Notice of Privacy Practices, and Financial Policy

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Backbone Family Chiropractic and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Backbone Family Chiropractic.

2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment, and health care operations consistent with the Backbone Family Chiropractic Notice of Privacy Practices.

3. I have been offered a copy of this office's Notice of Privacy Practices pursuant to HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. I also consent to the use of my health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

4. I understand that Backbone Family Chiropractic requires payment at the time of service and accepts ONLY cash, debit, and credit cards. While the office will happily provide information to help me file claims with my insurance company, I understand that the office does not file such claims for me, and that Backbone Family Chiropractic is not a contracted provider with my insurance company.

X

Patient or Authorized Person's Signature

Date