# Align Chiropractic Center Intake Form

**Personal Information**

Name: _____ Date of Birth: _____

Gender: □ Male □ Female □ Other Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

**Emergency Contact Information**

Name: _____ Relationship: _____ Phone: _____

**Health Information**

Primary Care Physician: _____ Phone: _____

Current Medications: _____

Allergies: □ Yes □ No If yes, please list: _____

**Medical History**

Do you have or have you had any of the following conditions? (Check all that apply)

□ Heart Disease □ High Blood Pressure □ Low Blood Pressure □ Diabetes

□ Seizures □ Cancer □ Arthritis □ Asthma

□ Depression/Anxiety □ Chronic Pain

□ Other: _____

**Lifestyle and Habits**

Do you smoke? □ Yes □ No

Do you consume alcohol? □ Yes □ No

Do you exercise regularly? □ Yes □ No

If yes, please describe: _____

Do you follow any specific diet? □ Yes □ No

If yes, please describe: _____

**Chiropractic History**

Have you been to a chiropractor before? □ Yes □ No

If yes, when was your last visit? _____

What was the reason for your visit _____

Was the treatment successful? □ Yes □ No

If no, please explain: _____

**Current Health Concerns**

What is your primary reason for seeking chiropractic care today?

_____

Please rate your pain on a scale of 0 (no pain) to 10 (worst pain): _____

When did the pain start? _____

Is the pain: □ Constant □ Intermittent □ Sharp □ Dull □ Throbbing □ Aching □ Burning

What activities aggravate your pain? _____

What activities relieve your pain? _____

Have you tried any other treatments for this issue? □ Yes □ No

If yes, please describe: _____

**Additional Information**

Do you have any other symptoms or conditions you would like to address?

_____

Is there anything else you would like the chiropractor to know?

_____

Additionally, I affirm that the personal and health history information I have provided is accurate and complete to the best of my knowledge.

_____ _____ / _____ / _____

**Patient or Authorized Person's Signature** **Date**

# Informed Consent and Agreement

**REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures**

I hereby request and consent to the performance of chiropractic treatments, adjustments, and other chiropractic procedures, including various forms of physical therapy, on me (or the patient named below, for whom I am legally responsible) by the licensed chiropractors who now or in the future treat me while employed by, working or associated with, or serving as back-up for the treating chiropractor. This includes those working at the clinic or office listed above or any other office or clinic.

Chiropractic care, like all forms of health care, offers considerable benefits but may also involve some level of risk. While the level of risk is most often minimal, rare complications have been reported. These include, but are not limited to, fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations, sprain/strain injuries, and irritation of a disc condition. One of the rarest complications associated with chiropractic care is a vertebral injury that could lead to stroke or death, occurring at a rate of approximately one instance per one million to two million cervical spine (neck) adjustments.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, overall health, and spinal health. They assist in determining whether chiropractic care is appropriate or if further examinations or studies are needed. Additionally, they help determine if care modifications or referrals to other healthcare providers are necessary. All relevant findings will be reported to you along with a proposed care plan prior to beginning treatment.

I understand that, as with any healthcare procedure, complications may arise during chiropractic adjustments. I do not expect the chiropractor to be able to anticipate and explain all risks and complications. I intend to rely on the chiropractor's judgment to determine the procedures that are in my best interest based on the information known at the time.

I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content. By signing below, I agree to the above-named procedures. I consent to the examination and chiropractic care, including spinal adjustments, as deemed necessary and reported following my assessment. I intend for this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

_____ _____ / _____ / _____

**Patient or Authorized Person's Signature** **Date**

**REGARDING:** X-rays / Imaging Studies

*Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

□ The first day of my last menstrual cycle was on Date: _____/_____/_____

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____ / _____ / _____

**Patient or Authorized Person's Signature** **Date**

# ALIGN CHIROPRACTIC CENTER NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

**PERMITTED DISCLOSURES:**

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different from residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

I have received a copy of Align Chiropractic Center Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me per my request. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ **Date of Birth:** _____ / _____ / _____

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

_____ _____ /_____/_____

**Patient's Signature** **Date**

## MEDICAL INFORMATION RELEASE FORM (HIPPA RELEASE FORM)

**Name:** _____ **Date of Birth:** _____ / _____ / _____

***Release of Information:***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

***Messages:***

Please call [ ] my home [ ] my work [ ] my mobile number: _____
If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

_____ _____ /_____/_____
**Patient's Signature** **Date**

## RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Michael R. Parzych DC P.A. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. I understand that all professional services rendered are charged to the patient and that it is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment and that Align Chiropractic Center reserves the right to add a $25.00 service charge to my account for any returned check or charge back. I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

_____ _____ /_____/_____
**Patient's Signature** **Date**

# Cancellation Policy for Align Chiropractic Center

At *Align Chiropractic Center*, we value the time and commitment of all our patients and staff. To ensure that we can continue to provide quality care, we have implemented the following cancellation policy:

- **24-Hour Notice Requirement**: We kindly ask that you provide at least 24 hours' notice if you need to cancel or reschedule your appointment.
- **Late Cancellation/No-Show Fee**: Appointments canceled without at least 24 hours' notice, or missed without prior notification, will incur a $25 fee.

**How to cancel or reschedule**

You may cancel or reschedule your appointment by:

- Calling us **954-748-3700**
- Sending a text message to **954-748-3700**

**Policy Disclaimer**

This cancellation policy is effective immediately upon scheduling your appointment, whether made online or in person.

We appreciate your understanding and cooperation as we strive to provide the best possible care for all our patients.

Warm regards,

*Dr. Michael Parzych and the team at Align Chiropractic Center*

**Client Signature**: _____ **Date**: _____

# Reimbursement and Payment Policy

*Align Chiropractic Center*

When signing up for a **Corrective Care Recommendation**, **Wellness Plan**, or as a **Pay Per Visit Patient**, please review and agree to the following reimbursement and payment terms:

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**Refund Policy**

**Corrective Care Recommendations and Wellness Plans**:

Partial Refunds are eligible **upon office discretion** from the date of purchase.

After sixty days, **no refunds will be issued**, regardless of the usage status of the plan.

**Cash Patient Services**:

Payments made for specific services or packages are subject to the same office discretion refund timeline. Unused credits will remain in your account and can be applied to future services as long as your account remains active.

**Policy Continuity**:

In the event of a **change in business ownership**, this reimbursement policy will remain in full effect and enforceable under the new ownership.

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**Out-of-Network Insurance Benefits**

Align Chiropractic Center can provide documentation (such as superbills) for patients seeking reimbursement through their **out-of-network benefits** with health insurance providers.

**Disclaimer**: There is **no guarantee** that your insurance company will provide reimbursement for services rendered. Coverage and payment depend entirely on the terms of your individual insurance plan.

Patients are responsible for understanding their insurance coverage and any associated policies or requirements.

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**Monthly Recurring Payments**

Patients who opt for **monthly recurring payments** enjoy discounted rates that are only valid as long as the payments continue uninterrupted.

**Unused Credits**

Unused credit after a year cannot be refunded but will stay on your account for future use, provided the account remains active and in good standing.

**Cancellation of Monthly Recurring Payments**:

Should monthly payments be discontinued or canceled, the patient acknowledges and agrees to pay the **standard adjusting fee of $65 per visit** moving forward.

Discounted rates are **exclusively available** to patients enrolled in monthly recurring payments or upon purchase of a **Wellness Package**.

**CareCredit Payment Policy**

Align Chiropractic Center accepts **CareCredit** as a payment option to make services more accessible for patients. The following terms apply:

**Eligibility Requirements**:

- Patients must apply for CareCredit and receive approval prior to using it for payment. Align Chiropractic Center does not facilitate or guarantee approval.

**Accepted Services**:

- CareCredit can be used for Corrective Care Recommendations, Wellness Plans, or other approved chiropractic services.

**Minimum Payments**:

- Patients using CareCredit must adhere to their payment agreement with CareCredit. Align Chiropractic Center is not responsible for any late fees, penalties, or non-payment issues with CareCredit.

**Refunds on CareCredit Payments**:

- Any refunds for services purchased with CareCredit will be processed in accordance with our standard **Refund Policy** and will be credited back to your CareCredit account.

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**Sharing of Credits**

- Sharing of credits is **only permitted** when purchasing **Wellness Packages in bulk**.
- Shared credits must be designated at the time of purchase and are non-transferable outside the designated recipient(s).

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**General Terms**

- This policy is effective upon signing up for a Corrective Care Recommendation, Wellness Plan, or Cash Patient agreement.
- All purchases indicate agreement to this policy, ensuring fairness and consistency for all patients.

If you have any questions or require clarification, please contact us at **954-748-3700**.

Thank you for choosing *Align Chiropractic Center* as your partner in health.

Warm regards,
*Dr. Michael Parzych and the team at Align Chiropractic Center*

**Client Signature**: _____ **Date**: _____