Athletic & Family Chiropractic
John Van Tassel, D.C.

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contradicted. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

PAYMENT POLICY

I understand that this office will file my insurance claim for me upon request and that any amount paid directly to this office by my insurance company will be credited to my account. However, I clearly understand and agree that I am personally responsible for paying fees for service (regardless of my insurance coverage) and at any time it can be requested that I pay all or part of the balance of my account.

I have read and understand the foregoing.

Patient's Signature _____ Date _____

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize John Van Tassel, D.C., and/or his staff to examine and/or treat my
Indicate Relationship: _____.

Full name of Child _____
Address _____
_____

Parent or Guardian signature _____ Date _____

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ATHLETIC & FAMILY CHIROPRACTIC
RELEASE OF MEDICAL RECORDS

TO: _____ DATE_____
(DOCTOR OR HOSPITAL)

ADDRESS_____

CITY_____ ST._____ ZIPCODE_____

PHONE #_____ FAX #_____

I hereby authorize the release of my medical records and xrays or copies of such and request they be transferred to:

John Van Tassel
2309 Wednesday St.
Tallahassee, FL 32308
Phone #: 850-385-5113
Fax #: 850-385-5601

A copy of this document is as official as the original.

_____ _____
Print full name of patient Signature of patient or parent/guardian

_____
Patient's Date of Birth

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Office Policies- Athletic & Family Chiropractic

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies.

Massage Therapy

Massage therapy is a valuable treatment form offered by our clinic. It is understood that the purpose of massage is for stretching and relaxation as well as performance enhancement for the athlete. It is not meant to diagnose or treat any illness, or any other physical or mental disorder, injury or condition. I have informed my practitioner about my state of health, and I have transmitted to him/her any recommendations and restrictions on the part of my physician insofar as massage is concerned.

Signature _____ Date _____

Patient Payment Policy

Payment for all services, including co-pays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than 45 days, there will be a finance charge of 5% per month.** In the event you do not have insurance coverage, we are here to serve everyone in this community. Therefore, part of this service means making sure that money is never a barrier to good healthcare. We offer various cash payment plans and are willing to work out a program that is appropriate to your situation. These flexible plans will be set up on a per patient basis after discussing your individual financial needs.

Our Policy on Health Insurance

We will be happy to file your primary insurance claim for you and do everything we can to insure you receive proper reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment.

I have read and received a copy of the Athletic & Family Chiropractic Policies and will honor them:

Print Name _____

Patient Signature _____ Date _____

Athletic & Family Chiropractic

John Van Tassel, D.C.

2309 Wednesday Street
Tallahassee, Florida 32308

Phone: 850-385-5113
Fax: 850-385-5601

Patient Name: _____

Please read and sign the following consents, releases and agreements.

1. CONSENT TO ROUTINE CLINIC SERVICES: I consent to the services being rendered during this visit on an outpatient basis by the doctor of chiropractic named above and or any other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back up for the doctor of chiropractic named above. I understand that I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic manipulative therapy, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that no guarantee has been make to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
2. AUTHORIZATION FOR DIRECT PAYMENT OF INSURANCE BENEFITS TO THE HEATHCARE PROVIDER AND CLINICS: I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.
3. MEDICARE CERTIFICATION AND PAYMENT REQUEST: I am applying for payment under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services to the provider(s) or organization furnishing the services or authorize them to submit a claim to Medicare on my behalf. Initial_____ Doesn't apply _____
4. AUTHORIZATION TO RELEASE INFORMATION: In obtaining payment for services, I authorize my healthcare provider (s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit an provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.

I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

1. Signature of Patient _____ Date _____

2. Signature of Representative _____ Date_____
   Relationship to Patient _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

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