**PATIENT INFORMATION**

Date:

Marital Status:

Last Name: First: Middle:

Sex:

Date of Birth: Social Security #:

Home Ph: Cell Ph: Cell Provider\*:

\*To receive text message appointment reminders please provide your Cell Provider

Patient Address:

City: State: Zip:

Email Address:

Employed By:

Emergency Contact Name/Relationship: PH:

How did you hear of our office? 🞏 Google 🞏 Friend/Word of Mouth

🞏Medical Referral 🞏 Insurance Website Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Patient’s insurance member ID/ claim information:

HEALTH INSURANCE OFTEN PAYS FOR MEDICALLY NECESSARY MASSAGE. PLEASE CHECK HERE IF YOU WOULD LIKE US TO CHECK YOUR INSURANCE.



I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, or various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic or doctor of physical therapy named below and/or other licensed personnel who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, there are some risks to treatment, 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend 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.

Dr. Jonathan Hancock, DC

Dr. Alexandra Ellison-Cherny, DC

Dr. Justin Spiegel, PT DPT CMP

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date



Financial Policy

The patient responsibility for an appointment is due on the day of service.

We make every effort to provide you with high quality chiropractic care and convenient financial options. For those patients with health insurance, our office participates with many insurance providers. If using health insurance, you will need to pay your estimated copay/coinsurance. Please note that we can only give you an ESTIMATE and not a guarantee of payment by your insurance company. We give estimates according to the benefits quoted to us by your insurance company.

Ultimately, your insurance company does not care about you or us. They care about money, and that is the harsh reality. The contract you sign with them leaves you responsible for any underpayment by them. Please review your insurance policy closely to understand your yearly maximum and how much of your insurance you may have used prior to your visit with us.

We accept checks, cash, and the following credit cards: Master Card, Visa,

American Express and Discover. Another option we offer is "Care Credit". This is a separate line of credit for health care needs. You can apply online at www.carecredit.com or call toll free 1-800-859-9975.

I understand the above policy.

Patient Signature Date

Changes to this Notice of Privacy Practices

Back to Wellness is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact: Dr. Jonathan Hancock by calling this office at 813 973-4747. If Dr. Hancock is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Back to Wellness reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Back to Wellness is required by law to comply with this Notice.

Complaints

Complaints about your Privacy rights, or how Back to Wellness has handled your health information should be directed to Dr. Jonathan Hancock by calling this office at 813 973-4747 If Dr. Hancock is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201

This notice is effective as of \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Back to Wellness with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

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Patient’s Name (print)

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Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Facility Signature Date

# CANCELLATION POLICY

We regret the need to implement the policy below, but we have had an increasing number of patients who fail to keep their scheduled appointments. As a courtesy, we agree to confirm your appointment by an automated reminder text and/or email, or call to you one day before your scheduled appointment. You will at that time have the opportunity to cancel, confirm, or submit a request to have someone from the office contact you to re- schedule. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call. The result of patients not canceling their scheduled appointment is that the physicians are then unable to accommodate those patients with sudden medical problems that require medical intervention.

All new patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment. If you cancel with less than 24 hours’ notice, or fail to show for your appointment, your credit card will be charged $45.00.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide a 24 hour cancellation notice of any scheduled appointment at The Back to Wellness Center, LLC.

The fee of $45.00 for any missed appointment will be charged to the credit card I provide. I understand that this fee is not reimbursable by my insurance carrier. The fee for the first cancellation or no show will be waived.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Credit Card # Expiration CVV Billing Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Patient Signature Date

# *\*This document will be securely shredded*

**LATE SHOW POLICY**

Our providers do their best to keep appointments on schedule. Out of respect for patients who have arrived on time for their appointment, you may be asked to reschedule your appointment if you arrive later than your scheduled appointment time. We will make every effort to honor your appointment as a “work in” appointment as the schedule allows. The policy is that new patients arrive 15 minutes prior to their scheduled appointment time and established patients arrive 5 minutes before their scheduled appointment time.

I hereby acknowledge and accept the above policy.

Patient Signature Date

Authorization to Release Protected Health Information

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information Requested from**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the above named office and any of its employees to disclose my Patient Health Information to:

The Back to Wellness Center LLC

27454 Cashford Circle Wesley Chapel, FL 33544

PHONE: 813.973.4747 FAX: 813.973.3799

Effective Dates of this authorization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_through \_\_\_\_\_\_\_\_\_\_

This authorization will expire at the end of the above period.

I understand I have the right to:

* Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
* Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
* Inspect a copy of Patient Health Information under federal law.
* Refuse to sign this authorization.
* Receive a copy of this authorization.
* Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

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Signature or Patient or Patient's Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature- The Back to Wellness Center Date

**The Back to Wellness Center, LLC.**

Jonathan Hancock, D.C.

Alexandra Ellison-Cherny, D.C.

Justin Spiegel P.T., D.P.T., C.M.P.

**OUR OFFICE POLICY REGARDING INSURANCE PLANS**

Our office is pleased to accept your insurance plan. The deductible and any amount that is not paid by the insurance company is the patient’s responsibility. The patient will be billed for any balance not paid by the insurance company within 60 days, unless other arrangements are made with The Back to Wellness Center. We will do our best to provide you an ESTIMATE of your responsibility based on information we gather from your insurance plan. We will file your claim forms and assist you in every way we can.

TIME OF SERVICE (TOS) DISCOUNT

What is a Time of Service Discount?

Whether your insurance plan covers chiropractic services or not, The Back to Wellness Center offers a Time of Service (TOS) Discount to everyone. There is approximately a 20% savings if you choose to pay for your services with this method of payment. In order to qualify for this discounted payment option, you would have to agree to the following:

All services are paid THE SAME DAY they are provided (at the discounted rate).

You would submit to your insurance company the paperwork for the services provided at our office. We would not do this on your behalf.

You understand that your insurance company may or may not reimburse you at a later date for the services performed at our office.

I have read the above and understand my options for payment of services rendered at The Back to Wellness Center. Please initial option 1 or 2 below.

Self-Pay

1. \_\_\_\_\_\_\_ I choose to take the TOS discount. I understand that I will pay for the services at the time of service and I will be responsible for sending the claim in to the insurance company in order to be reimbursed.

Insurance

2. \_\_\_\_\_\_\_I choose not to take the time of service discount. I understand that The Back to Wellness Center will bill my insurance and I will be responsible for any outstanding amounts applicable after any insurance payments or balances applied toward my deductible/copay.

Name Date