Knobbs CHIROPRACTIC

Name: _____Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: ___ Female ____ Male SS# _____

E-Mail: _____ Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Would you like text message appointment reminders? Yes No

Your Employer Information **OK to call at work? ___Yes ___ NO**

Employer: _____ Occupation: _____

Address: _____ City/State/Zip: _____

WORK STATUS: ___Full time ___ Part time ____Disabled ___Student

Emergency Contact Information: Name: _____Phone #: _____

Address: _____City/State/Zip_____

Spouse Information: Name: _____

Date of Birth: _____Cell Phone: _____ Work Phone: _____

Spouse Employer Information

Employer: _____ Occupation: _____

How did you hear about Dr. Knobbs? _____

Who is your primary care provider? _____

If under 18 years: I hereby grant permission for my child to receive treatment by Dr. Dale W. Knobbs:

ASSIGNMENT AND RELEASE: I certify that I, and my dependent(s), have insurance coverage with _____ and assign directly to Dale W. Knobbs DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Knobbs may use my health care information and may disclose such information to the above names insurance company, or other company (is) and their agents for the purpose of obtaining payment for related services. This consent will be ongoing.

Signature (Parent or Guardian's signature if under 18 years of age): _____

Printed Name: _____

Date: _____ ***Relationship to patient: ___ Self ___Spouse ___ Child ___ Other***

INSURANCE INFORMAITON- Please provide your insurance card and driver's license when checking in:

Who is responsible for this account? _____

Name of Insured: _____

Birth Date: _____ ***SS#*** _____

Relationship to patient: ___Self ___Spouse ___Child ___Other_____

Insurance Carrier: _____ ***ID#:*** _____ ***Group#*** _____

PATIENT HIPPA FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1997 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers-directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments.

I have been informed by Knobbs Chiropractic LLC of your Notice of Privacy practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice Of Privacy Practices (NPP) prior to signing this consent. I understand that the office of Dr. Dale W. Knobbs has the right to change its NPP from time to time and that I may contact them at any time at the address listed below to receive an updated copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Date: _____

Office Signature: _____

Dale W. Knobbs D.C.

4305 Beverly St. Suite B, Colorado Springs, CO 80918 Phone: 719-258-5656 Fax: 719-582-1134
Updated 2/3/2023

INFORMED CONSENT AND TREATMENT AUTHORIZATION FOR KNOBBS CHIROPRACTIC

The nature of chiropractic treatment: The doctor will use his/her hands or mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, or dry hydrotherapy may also be used.
Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, filamentous sprain, dislocation of joints, or injury to the intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary produces could produce skin irritation, burns or minor complications.
Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million. Screening procedures can even further reduce this risk. The probability of adverse reaction due to ancillary procedures is also considered "rare".
Other treatment options, which could be considered, may include the following:

Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.

Medical Care. Typically, anti-inflammatory drugs, tranquillizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.
I have read or have had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. I intend this consent for to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

_____	_____	_____
Patient's Name	Signature	Date
_____	_____	_____
Witness's Name	Signature	Date

Treatment Authorization
I herby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment to services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary; I will become responsible for all charges, fees and attorney fees.

Patient's Signature: _____ Date_____

Consent to treat a minor
I (we) being the parent, guardian or custodian of the minor being _____, age_____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-Rays, laboratory tests, and any treatment that in their judgment is deemed necessary.

DR. KNOBBS OFFICE FINANCIAL POLICY

NOTE: ALL PATIENTS MUST COMPLETE OUR ENTRY AND INSURANCE FORMS AND AGREE TO THIS FINANCIAL POLICY BEFORE SEEING DR. KNOBBS.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. It is the goal of this office to provide quality care at a reasonable cost. By adhering to our policy, this can be achieved. Please understand that payment or your co-payments, deductibles, co-insurance or your entire bill must be made at the time of your treatment unless other arrangements have been made. The following is a statement of our Financial Policy, which we require that you read, and sign prior to treatment.

INSURANCE

This office accepts assignment for many indemnity insurance plans, **HMO's** and **PPO's**. Please refer to your policy for specifics on charges that are or are not covered. We may bill all insurance companies as a courtesy to you if current insurance information is provided. Your insurance policy is a contract between you and your insurance company. We are not a party to that (these) contract(s). If your insurance company or you have not paid for your services within **90 days,** an outside collection agency may be utilized. Please contact our office at **719-528-5656** regarding any questions on your billing.

USUAL AND CUSTOMARY RATES

This office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

SERVICE FEE ON RETURN CHECKS

A service fee of $30.00 or 5% of the face amount up to $50.00 will be charged on all returned checks. You may be sued for damages of the times the amount of the check up to a maximum of $500.00 Return checks will be electronically re-deposited for the face amount and service fee.

I further authorize release of necessary medical records to my insurance carrier and direct payment to the provider of care. **In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I understand that 40% of the unpaid balance, representing the cost of collection, will be added if this account is turned over to a collection agency, and I agree to be held fully responsible for the sum thus due. I have read, understand, and agree to the Financial Policy.**

_____ Date _____

Signature of patient or legal guardian for the person receiving care – financial policy 10/11/2016 revised.

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