HERNANDEZ CHIROPRACTIC

1125 Linda Vista Drive suite 102

San Marcos, CA 92078

**HIPPA PRIVACY AND SECURITY POLICY**

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations.

I have been informed that I may review the practice/clinic’s “Notice of Privacy Practices” for a more complete description of uses and disclosures before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the requested. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revise this consent at any time, by making a request in writing, except for my information already used or disclosed.

Signature: Date:

If signed by patient representative, state relationship to patient

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**Acknowledgement of Special Promotional Fee**

I acknowledge that Dr. Hernandez’s initial fee with (coupon / referral / card / other: )

Is a special PROMOTIONAL FEE and not our Usual and Customary fee.

As such, I understand that the results of any of the tests, including x-rays, tests, examinations, range of motion studies, scans or any other procedures performed on me or in the special promotional fee shall not be released to me or to any other doctor or hospital or to any other person or institution unless and until the full and customary fees for the services are paid to Hernandez Chiropractic.

I hereby waive my usual rights to take physical possession of originals or copies of the information gained from the aforementioned x-rays, tests, procedures, etc until the full and customary fees for the services are paid to Hernandez Chiropractic. I further understand that I many not file any third party claims for the reimbursement of this special promotion fee (such as insurance, major medical, worker’s compensation, automobile accident, etc.)

 Print Name Signature

 Date Witness

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**REQUEST FOR X-RAYS & INFORMATION**

TO:

ADDRESS:

I, (PRINT NAME) BIRTHDATE:

REQUEST THE FOLLOWING INFORMATION:

[ ] X-RAYS [ ] HISTORY [ ] RECORDS [ ] REPORTS [ ] DIAGNOSIS

CONCERNING MY:

[ ] ILLNESS [ ] ACCIDENT [ ] INJURY [ ] OTHER:

TO BE RELEASED TO: HERNANDEZ CHIROPRACTIC

 1125 Linda Vista Drive suite 102

 San Marcos, CA 92078

Phone: 760-591-4878

Fax: 760-591-7878

I understand that I have a right to receive a copy of this authorization upon my request.

According to Section 1795 of the California Health & Safety Code, “the patient, or legal representative of a minor child, has the right to require a health provider to release original x-ray on a loan basis to other providers within 15 days of a written request because the patient alone owns the information right contained therein.”

Signature: Date:

[ ] Patient [ ] Parent [ ] Spouse [ ] Guardian

**PREGNANCY RELEASE**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates/staff have permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period:

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**TERMS OF ACCEPTANCE**

When a patient seeks Chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

**TO LOCATE, ANALYZE AND CORRECT**

**SPINAL INTERFERENCE TO THE NERVOUS SYSTEM**

The purpose of the nervous system is to control and coordinate all bodily functions.

Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote natural health.

**WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S)**

**OTHER THAN VERTEBRAL SUBLUXATIONS.**

**WE OFFER NO TREATMENT OF CONDITION(S) OR DISEASE(S)p**

**OTHER THAN VERTEBRAL SUBLUXATIONS.**

**WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).**

**THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO IT’S FULLEST POTENTIAL.**

I, (print name) , having read the above statement and understanding it fully, do undertake chiropractic health care on its basis.

Signature: Date:

Witness: Date:

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**Case Types and Charges**

 (All fees are standard and primarily based on our professional association’s guidelines.)

Our experience has shown that it is important to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment, and you may choose the plan which best fits your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary, please let us know. Our main concern is your health and well-being, and we will do our best to help you.

**Case #1 – General Health Insurance**: If you have insurance that covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance card on or before your second visit. Until we have the completed, necessary insurance information to verify Chiropractic coverage, you will be required to pay for your care. After we verify your insurance company’s benefit details, we will discuss them with you. Most insurance companies will not cover “maintenance” care and therefore, we can offer other arrangements if your condition requires further care beyond your insurance limits.

**Case #2 – Private Pay / Cash**: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

**Case #3 – Industrial (Work-Related) Injury**: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

**Case #4 Auto Injury**: You need to supply us with the accident report, your car insurance, health insurance, liable party’s insurance, and attorney information (if applicable). Until necessary insurance information is gathered and benefits verified, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are required to bring the check to us.

**I QUALIFY FOR, AND UNDERSTAND, PLAN #\_\_\_\_\_\_\_\_\_ REQUIREMENTS.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**