PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we may not accept you as a patient until we are absolutely certain we know what is causing your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

Patient Information

Name: ______________________ Age: ________ Gender: ☐ M ☐ F

Address: ______________________ Home Phone: ( ) ______________

City, State, Zip Code: ______________________ Work Phone: ( ) ______________

E-mail: ______________________ Cell Phone: ( ) ______________

Date of Birth: ____________ Social Security: ____________ Marital Status: ☐ S ☐ M ☐ D ☐ W

Occupation: ______________________ Retired: ☐ Yes ☐ No

Spouse's Name: ______________________ Spouse's Phone: ( ) ______________

How were you referred to this office? (Facebook, YouTube, other) ______________________

In Case of Emergency

Name: ______________________ Relationship: ______________

Home Phone ( ) ______________ Cell Phone ( ) ______________

Purpose for This Visit

Reason for this visit: ____

DECLARATION I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I also agreed to provide all necessary information toKai Care Chiropracticpersonnel to comply with the reporting and claims process to the insurance company. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CANCELATION POLICY: We have a 24-hour cancellation policy for individual appointments. Late arrivals may result in a shortened appointment or rescheduling (charges may apply). To cancel or change your appointment, please text (801) 606-3396 (not call) directly, Facebook messages do not apply.

Patient's Signature or Legal Guardian: ______________________ Date: ____________

Name of Legal Guardian: ______________________ Relationship: ____________

Consent for Use or Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Patient's Signature: ______________________________ Date : ____________________

Patient's Name: ____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded: ____________ County, State of Guardianship: ____________________

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature: ______________________________ Date : ____________________

218 West 540 North, Orem, UT 84057

Authorization of Care

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. 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 the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic and/or other licensed Doctors of Chiropractic or those working at the clinic of office who now or in the future treat me while employed by, working or associated with Kai Care Chiropractic, or serving as a backup for the Doctor of Chiropractic.

I will have the opportunity to discuss with the Doctor(s) of Chiropractic, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, stroked, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 on the facts then known is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I am also aware that the Doctor of Chiropractic has an open adjusting area, which all the various modes of adjusting, and physical therapy on me (or the patient named below, for whom I am legally responsible) will be performed in this open adjusting area, unless otherwise stated.

I have read, or have had read to me, the above consent. I will have the opportunity to ask questions, and all my questions will be answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

To be completed by patient or patient's representative, if the patient is a minor or physically/legally disabled

____
Patient's Name

____
Patient's Signature

____
Name of Patient's Representative

____
Signature of Patient's Representative

Because of the HIPAA privacy rule we are not allowed to disclose any information unless authorized by you. Please indicate below the name and date of birth of the persons you are authorizing to contact us and request information with regards your account.

Name: ______________________ DOB __________

Name: ______________________ DOB __________

____
Relationship with Patient

____
Date Signed

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Kai Care Chiropractic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

(YOUR) Insurance Information		**(OTHER/AT FAULT)** Insurance Information	
Insurance Company		Insurance Company	
Mailing Address (for billing purposes)		Mailing Address (for billing purposes)	
Claim/Case Number		Claim/Case Number	
Policy Number		Policy Number	
Adjuster's Name		Adjuster's Name	
Phone / Extension		Phone / Extension	

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

Date of Accident: ____________________ Where did the Accident took place: ______________________________

Describe how Accident occurred: ____

____

____

At the time of the Accident, were you: ______ Driver ______ Passenger ______ Pedestrian ______ Other

Did you report the Accident (Police)? ☐ Yes ☐ No Did you need? ____ Ambulance ____ Hospital ____ Other

Please describe your vehicle: ________________ Year _______________ Make _______________ Model

Are you the vehicle owner? ☐ Yes ☐ No If no, Name of owner: ______________________________

Lien Contract

FOR: Dr. Jeremiah Hernandez D.C.
Kai Care Chiropractic and Wellness
218 West 540 North, Orem, UT 84057
Telephone (801) 606-3396 Fax (801) 606-3398

RE: **Payment Contract for Pending Accounts**

Name of Patient: ______________________________ Account #: ______________

I offer this Payment Contract to the above mentioned business and authorize and request that my lawyer (if no lawyer then insurance) to pay directly to this business whatever amount that is debited and established as services for my behalf directly after any settlement or judgment. Said amounts, plus interest, will be paid after the processing of any settlement, judgment or verdict after the subtraction of the fees due to the lawyers and the costs of the case.

I understand that I am directly and totally responsible to said business for all the reasonable bills submitted for services given to me and that this agreement is made solely for the additional protection of the business and in consideration of their expectation of complete payment. Furthermore, I understand that such payment is not conditional on any settlement, judgment or verdict.

Patient's Signature: ______________________________ Date: ______________

The below signed, being the lawyer of record of the above mentioned patient, agree with this to observe all the above mentioned terms, and agree to extract such amounts from whichever settlement, judgment or verdict available after excluding all due fees and costs of the case.

Lawyer's Signature: ______________________________ Date: ______________

I understand completely that whatever amount is owed to the above mentioned business will be taken from whatever payment that the client receives.

ACCEPT

With this I accept the provisions of this agreement. I understand that this agreed Payment Contract will not be in effect until I have a properly executed copy of this agreement.

Clinic Signature: ______________________________ Date: ______________

Dr. Jeremiah Hernandez D.C.
Kai Care Chiropractic and Wellness