Accelerated Chiropractic
& Natural Healing Center, LLC

Randy Hamling, D.C
707 Atlantic Ave.
Morris, MN 56267
(320) 585-7246
acceleratedchiro@gmail.com

Patient Information

(* Denotes Required Fields)

*Name:_____(Last Name), _____(First Name) (_____)(Preferred First Name) ___(MI) *Social Security #_____ *Birth Date: __/__/____ (MM DD YYYY)

*Gender: ❑ Male ❑ Female *Marital: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

*Race: ❑Caucasian/White ❑African-American/Black ❑Asian
❑Central/South American ❑Native American ❑Pacific Islander

*Ethnicity ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I Decline to Answer

*Mailing Address:_____ *City:_____ *State:_____ *Zip:_____

*Home Phone:_____ *Cell Phone:_____ *E-mail address:_____

*Occupation:_____ *Employer:_____

*Employer's Address:_____ *City, State, ZIP:_____ *Office Phone:_____

*Family Medical Doctor:_____ *Medical Facility:_____

*In Case of Emergency, who should we contact?_____ *Phone #:_____

*How would you like to receive appointment reminders? ❑Text Msg. (*Cell Carrier_____) ❑E-mail
❑Text No Appointment Reminders

*Smoking Status: ❑Every Day Smoker (#years___) ❑Former Smoker (#years___)
❑Occasional Smoker (#years___) ❑Never Smoker

Current Medications ❑None	Dosage and Frequency (i.e. 5mg once a day, etc)
Medication Allergies ❑None	**Reaction**

*How did you hear about us? (Check all that apply)

❑Family Member/Friend/Doctor (Who May We Thank?_____)
❑Fair/Event ❑Lecture/Business Appreciation
❑Our Website ❑Facebook ❑Clinic Sign/Driving By
❑White Pages ❑Yellow Pages
❑Online Directory (Which Directory?_____)
❑Other_____

*Patient's Signature:_____ *Date: __/__/____ (MM DD YYYY)

Guardian's Signature Authorizing Care:_____ *Date: __/__/____ (MM DD YYYY)

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CONSENT FOR TREATMENT, THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF BILLING, TREATMENT AND FILE MAINTENANCE

NAME_____, _____

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations of the uses and disclosures we may make of you protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before you sign this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Contact Person. Please understand that revocations of this consent will not affect any action we took in reliance on this consent before we received your revocations and that we may decline to treat you or to continue treating you if you revoke this consent.

Informed Consent: I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved you may experience a 'pop' call cavitation as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also know as Oculosympathetic Palsy), costovertebral strains and separations. Rare complications include, but are not limited to stroke. The most common complication or complaint following a spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which could cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health care information to carry out treatment, payment activities and health care operations.

Signature _____ Date_____/_____/_____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name _____

Relationship to Patient _____

You are entitled to a copy of this consent after you sign it

Authorization and Assignment of Benefits/Financial Policy

ACCELERATED CHIROPRACTIC & NATURAL HEALING CENTER, LLC
707 Atlantic Ave.
Morris, MN 56267
Tel: 320-585-7246 Fax: 320-585-7247

1. I hereby authorize **Accelerated Chiropractic & Natural Healing Center, LLC** to release any and all appropriate information concerning my health condition to any insurance company, adjuster, attorney requesting it in order to process any claim for re-imbursement of charges incurred by me.

2. I understand that I am the owner of my insurance policy and it is ultimately my responsibility to know my policy details and what personal financial contributions will be expected. **Accelerated Chiropractic & Natural Healing Center** will, as a courtesy, verify my policy is active and inform me of what services **should be** covered per their contracts with my insurance and what limitations are posed under my specific policy. I understand the benefits quoted to **Accelerated Chiropractic & Natural Healing Center, LLC** by my insurance company are **NOT** a guarantee of payment and I assume financial responsibility for non-covered services and insurance assigned financial obligations. I agree to take an active role in collecting payment from my insurance company by completing necessary documentation and informing this office of changes in insurance policies.

3. As a courtesy to me, **Accelerated Chiropractic & Natural Healing Center, LLC** will bill my insurance company, and any secondary carriers, and wait up to 90 days for payment. If after 90 days my insurance carrier has not paid a claim, I agree to pay for the outstanding charges. I understand **Accelerated Chiropractic & Natural Healing Center, LLC** will send me a payment receipt.

4. I hereby authorize and assign direct payment to **Accelerated Chiropractic & Natural Healing Center, LLC** for any and all sums owed now or hereafter by any insurance company, which may or may not cover the services provided to me by **Accelerated Chiropractic & Natural Healing Center, LLC.** I accept full financial responsibility for any non-covered services and patient responsibilities assigned by my insurance.

5. I agree to pay for co-pays on the days of service and deductible amounts as they get assigned to my account. I understand that **Accelerated Chiropractic & Natural Healing Center, LLC** has the capability to securely store credit card information within a 3rd party payment system. As a backup method of payment, I consent to putting a credit card on file and consent to run my card to pay for non-covered services and insurance assigned deductible amounts/co-pays should I happen to not pay for these on my own in the first 3 billing cycles (90 Days). In the event that my card declines, I understand and agree that a 1.5% monthly (18% annually) service charge on any outstanding balance over 90 days old will be assigned and turned over to a collection agency if I fail to make an attempt to satisfy my financial obligations. (Accelerated Chiropractic is willing to arrange payment plans to show an attempt to satisfy these obligations.)

6. I acknowledge that I may have been charged a deposit to hold my initial visit at **Accelerated Chiropractic & Natural Healing Center, LLC**. I acknowledge that my deposit will carry over to a rescheduled appointment if I reschedule prior to 24 hours of the appointment. I acknowledge that if I fail to attend or reschedule within 24 hours, I forfeit that deposit and would need another deposit to reschedule. ALL deposit dollars will be put towards any patient responsibilities my insurance assigns. If my insurance covers 100% of ALL services rendered, the deposit will be refunded to the card I originally provided.

7. I agree to pay any and all amounts not paid by the insurance company. If any action must be taken by **Accelerated Chiropractic & Natural Healing Center, LLC** to enforce its rights under this authorization and assignment of benefits, I understand that I may be held responsible for any legal costs incurred by taking such action.

8. I acknowledge the terms of this agreement and that they will likely change as the healthcare reimbursement rules/reimbursement rates evolve in the future. I agree to future changes of this agreement and acknowledge this may occur without being informed of such changes as they happen.

I have read and understand all aspects of this financial policy of Accelerated Chiropractic & Natural Healing Center, LLC and assume the personal financial obligations for services of receiving care, regardless of the healthcare results. If I fail to follow any part of this agreement Accelerated Chiropractic & Natural Healing Center, LLC has the right to terminate their professional services and I agree my balance will be due in full at that time.

_____ / / _____

Signature of Patient/Guardian Date MM DD YYYY

_____

Printed Name

Form Edited 02/23/2022

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ACKNOWLEDGEMENT OF NON-CONTRACTUAL SERVICES
ACKNOWLEDGEMENT OF NON-COVERED SERVICES

I have been advised that my insurance company may deny the services rendered by Accelerated Chiropractic & Natural Healing Center, LLC. Therefore, I acknowledge and accept liability for payment of those services.

Accelerated Chiropractic & Natural Healing Center, LLC, will not be bound to the contractual agreement with my insurance company in regards to non-contractual services. Therefore, I agree to pay the balance due on these services after my insurance company processes the claim. This includes what the insurance company may put in "provider reduction," "contractual agreement," etc.

Some insurance carriers do not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the services and healthcare products below.

Services	Applicable Insurance Carrier	Reason Insurance May Not Pay:	Cost of Service	Time of Service 20% Discount
Initial Exam/Progress Exams	Medicare	Non-covered service	Varies	(-20%)
X-Rays	Medicare	Non-covered service	Varies	(-20%)
Extremity Adjustment	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$30	$24
Therapeutic Modalities:				
- Intersegmental Traction	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$25	$20
- Electrical Muscle Stim.- Supervised	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$25	$20
- Electrical Muscle Stim.- Attended	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$30/$15	$24 / $12
- Ultrasound	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$20/$10	$16 / $8
- Manual Therapy	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$40/$20	$32 / $16
- Strapping	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$25	$20
- Pelvic Stabilizers (Shoe Orthotics)	Most Insurance Carriers	Non-contractural service	Varies	No Discount
- Supplements/Retail Products	Most Insurance Carriers	Non-contractural service	Varies	No Discount
Other:				

We do our best to advise you when we recommend a service that will benefit your treatment if that service is covered by your insurance or not. This advisory is to let you know these non-covered services. With this information, it is your responsibility to recognize when a recommended therapy or other non-covered service is about to begin, to advise the doctor if you would choose to decline such a procedure at that time. This is an acknowledgement that you understand the above services are not covered by my insurance and should you choose to still receive the therapy you agree to pay for them the day they are rendered to receive the time of service discount.

SIGNATURE DATE

_____ _____ / / _____
MM DD YYYY

_____ /
PRINTED NAME

Form Edited 02/10/2022