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PATIENT REGISTRATION INFORMATION

Name:_____
Last Name First Name Middle
InitialDate of Birth: ___ / ___ / ___ Social Security #: _____ - ____ - _____

Address: _____ Apt. # _____ City: _____

State: _____ Zip: _____Home Phone: (____)_____

Cell Phone: (____)_____ Work Phone: (____)_____

Email:_____

Marital Status: __ Single __ Married __ Divorced __ Widowed Sex: __ Male __ Female

Race: __White __Black__Asian __Hispanic/Latino__Not Hispanic/Latino __Other__Declined

Emergency Contact Information:

Name:_____Relationship:_____

Address: _____ City:_____State: _____

Zip: _____Home Phone: (____)_____Work Phone: (____)_____Cell

Phone(____)_____

Referral Source: Whom may we thank for referring you to our practice?
_____Internet:____Another Patient:_____Other:_____

_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I understand that the practice of chiropractic is not an exact science, that individuals respond differently to treatment, and that there are no guarantees of the result of any treatment. I understand that the examination and treatment involves certain risks and those risks have been explained to me or provided to me. I do not expect the doctor to anticipate and explain all imaginable risks and/or contradictions, and I wish to rely on the doctor to exercise her judgment based on the facts known to be in my best interest during the course of treatment. I understand that the doctor is a licensed chiropractor in the state of Texas and such is licensed to employ objective or subjective means without the use of drugs, surgery, x-ray therapy, or radium therapy for the purpose of ascertaining the alignment of the vertebra and/or extremity when they are misaligned, in order to help cure or resolve musculoskeletal symptoms that result from such misalignment.

I have read and understood the above consent for chiropractic treatments and care. I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures. I have also had the opportunity to ask questions regarding this consent and my treatment plan.

Patient's Name: (PLEASE PRINT) _____
Patient's Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian of Minor: _____
Parent/Guardian Signature: _____ Date: _____

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HIPPA NOTICE OF PRIVACY PRACTICE

Patient's Name _____

By my signature below, I hereby authorize Clearly Aligned (Dr. Cori Seyhoon and "the practice") to disclose my protected health information (PHI) so that Dr. Seyhoon may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's treatment, payment and health care operations (TPO), (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

With this consent, Clearly Aligned may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, such as appointment reminders, insurance issues, and any calls pertaining to my clinical care, including laboratory results.

With this consent, Clearly Aligned may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient financial statements. Please check your preferred contact method.

___Email/Patient Portal ___Mail ___Phone

With this consent, Clearly Aligned may speak with the following. List family members, friends, etc. whom you would like to have access to your protected health information to assist the practice in carrying out TPO, such as discussing any open or unpaid balance of my financial account, including visit reason, insurance-related matters, or any other medical issues.

Name: _____, Relationship

Name: _____, Relationship

I have the right to request that Clearly Aligned restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Clearly Aligned to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Clearly Aligned may decline to provide treatment to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Clearly Aligned reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained through our office.

I have reviewed this office's Notice of Privacy Practices (HIPAA), which explains how my medical information can be used and disclosed. I understand that I am entitled to receive a copy of this document.

Print Name: _____

Signature:_____ Date:_____

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Patient Guidelines

Fees: Clearly Aligned reserves the right to make changes to the fee schedule at any time for any reason. Please contact the office if you have any questions about fees.

Initial Exam - Please come dressed in comfortable clothes (i.e. workout attire, or loose clothing), so the doctor can perform a comprehensive physical, chiropractic, orthopedic and neurologic exam based upon your complaint. The doctor will spend approximately 45-60 mins. with you during this visit. An extended exam is 60-90 minutes. The initial exam also includes an in-depth report of findings and introduction to wellness coaching.

Progress Exam - This exam is done as the patient transitions through various stages of care in his, or her treatment plan. The doctor will review what progress has been made and what additional suggestions, or corrections need to be made at that time.

Adjustment- This visit includes evaluation and treatment of the complaint area. Treatment includes the chiropractic adjustment of restricted spinal and extremity musculoskeletal segments. This appointment is best for wellness, or maintenance patients who have undergone some chiropractic care in the past.

Office Visit / Chiropractic & Myofascial Treatment (30 mins.) - This visit includes adjustments to the spine and extremities, soft tissue treatment (myofascial release, trigger point therapy, stretching), exercises, and rehab.

Office Visit (60 mins) - This visit includes adjustments to the spine and extremities, soft tissue treatment (myofascial release, trigger point therapy, stretching), exercises, rehab, neuromuscular re-education, and/or wellness coaching.

Forms of Payment: Please let us know if you have any questions regarding payment.

- Cash
- Check
- MasterCard/Visa/American Express

Appointments: Please call, e-mail, or text message in advance to make an appointment to ensure that there is an appointment time available.

Cancellations/No Show: Unless due to an emergency, there will be a **$45 no show fee strictly enforced for any scheduled appointment missed that was not called and rescheduled 24 hours in advance**. Clearly Aligned reserves the right to offer one (1) grace period. If a patient repeatedly is unable to make scheduled appointments, Dr. Seyhoon reserves the right to terminate care with the patient.

Request for Copies of Medical Records: Kindly give our office 48 hours notice to prepare your request. Patients will be required to sign a release of record form.

Email: In order to provide future appointment confirmations, office appointments, newsletters, educational articles, and/or other information from Clearly Aligned, we would like permission to use your email and/or your cellular telephone number. I understand that the above information will be kept private and confidential, and I give permission for Clearly Aligned to e-mail and/or text me as needed. Email Address: _____Cell Phone_____

Phone and Address Changes: Please notify us immediately so that we may update our records.

Signature of Patient/Guardian:_____ Date:_____

Assignment of Benefits

Consideration: In order to facilitate the ability of **Cori Seyhoon, D.C., CCSP, dba Clearly Aligned** to collect its charges directly from various payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the office's services, agree to the following and direct all payers as follow:

Partial Assignment of the Cause of Action & Assignment of Proceeds: I, hereby assign, in so far as permitted by law, all of my rights, remedies and benefits to **Cori Seyhoon, D.C., CCSP, DBA Clearly Aligned** as well as any and all causes of action that I might have now or in the future against any payer to the extent of my charges, the right to settle or otherwise resolve such causes of action as the office sees fit. I further assign my right to receive any proceeds from any payer to the above-mentioned provider with respect to my charges. Consistent with these rights, I hereby direct any and all payers, to pay the proceeds directly and immediately to and exclusively in the name of **Clearly Aligned** in the amount of my charges.

Other terms: I understand that I remain personally responsible for my charges. Consistent with the law or contract, I agree to pay the full amount of my charges upon demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the office shall not constitute a waiver of the office's right to receive payment in full. I understand that at any time, I can request a copy of my total charges.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection to **Clearly Aligned** regarding my charges. I further direct each attorney to provide immediate notice to the office regarding any proceeds received by the attorney, to promptly pay the charges in full out of such proceeds and to provide a full accounting of such proceeds to the billing office.

I authorize and direct the office to submit my charges to any and all payers including, without limit, my health benefit plan. I understand however, that in the event that my charges are submitted to more than one payer, I hereby authorize and direct the office to apply any proceeds received from one payer to any reductions, write offs or discounts, issued by another.

I authorize **Clearly Aligned** to endorse or sign my name on any and all checks listing me as a payee, which are received by the office for payment of charges incurred by me, my spouse or my dependents. I further authorize the office to apply any credit balances on my charges to any other outstanding charges still owed by me, my spouse or my dependents, regardless of whether these other charges are related to my condition.

This agreement shall not be modified or revoked without the mutual written consent of the office and myself. I also agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of **Clearly Aligned** and myself. I have read and understood the conditions, terms and purpose of this contract.

Patient Name: (PLEASE PRINT) _____

Patient/Guardian Signature:_____Date: _____