Personal Information

First Name: ___________________________ MI: ___________ Last: ________________________

Address: ______________________________ City/State/Zip _____________________________________

DOB: ______/_______/_____ Sex: ____________

Phone: (______) - _______-_______ Type: H / Cell Email: _____________________________________

Referred By: ____

Do you consent to receiving appointment reminders via text? YES / NO
Do you consent to receiving e-statements? YES / NO

****Text and data rates may apply Initials: __________

Please read the following carefully

I understand, and agree that health and auto accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that AllStar Chiropractic will prepare any necessary reports, forms, and medical records to assist me in making collections from said insurance company. I also authorize that any amount paid directly to AllStar Chiropractic will be credited to my account upon receipt.
AllStar Chiropractic will make every effort to collect from my insurance company; however, all services rendered to me are charged directly to me and that I am personally responsible for payment. (Detailed financial policy to follow).

I 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.

Signature: ____ Date: ________________________________

Relationship if under 18: __________________________________

555 W Schrock Road, Suite F. Westerville, Ohio 43081
p. 614-891-1800 f. 614-891-8047
info@AllStarchiro.net

Financial Policy

Thank you for choosing AllStar Chiropractic & Wellness for your chiropractic and wellness needs. The following is a statement of our Financial Policy, which we require you to read and sign prior to any care with AllStar Chiropractic.

We will:

- Check your insurance policy to determine your coverage for Chiropractic and Acupuncture Care
- Advise you on what is covered, what is not, and what any out-of-pocket cost there will be, if any
- Let you know that verification of benefits is not a guarantee of payment, you are ultimately financially responsible for any charges incurred
- Allow you, if you chose, not to bill your insurance for rendered services and pay the cash rate. ** a waiver is required** (for in network insurance policies only)

It is our policy to:

- Collect all co-pays at the time services are rendered
- Co-insurance amounts can be estimated at the time of service, but payment is always required once benefits are processed
- Collect any amount applied to your yearly deductible (in network insurances' only)
- Collect full payment for cash services the day services are rendered
- Charge a $50 fee on all returned checks

Usual and Customary Rates:

AllStar Chiropractic & Wellness will charge what is usual and customary per our provider agreement with your insurance company for our area. You are responsible for payment for any services that are not covered by your insurance that are rendered to you.

Acceptance of Assignment:

By accepting assignment, we will direct your insurance company to make any payments for all billable services rendered to you by AllStar Chiropractic & Wellness directly to AllStar Chiropractic & Wellness. We agree to accept any in-network insurance's approved amount for billed services.

Signature: ____ Date: _____________________________

Relationship if under 18: _______________________________

Missed Massage Therapy Appointment Fee

Our Massage therapists work in a completed appointment-based environment. It is almost impossible to fill an abandoned appointment or an appointment that is not cancelled within 24 hours' notice.

Therefore, any massage therapy appointment not cancelled within 24 hours will be assessed a **$35 cancellation fee.** This fee must be paid prior to rescheduling with our massage therapists.

Chiropractic appointments that are not cancelled within 24-hours are subject to a cancellation fee of $25.00.

Signature: ____ Date: ______________________________
Relationship if under 18: ________________________________

Notice of Privacy Practices

I have been notified of the privacy practices at Allstar Chiropractic, which is kept on file within the course of business in the office if I want to receive a copy.

(please check one)

________I have requested and received a copy of Allstar Chiropractic's Privacy Practices.

________I have been made aware of Allstar Chiropractic's Privacy Practices; I have no need to receive a copy. I do understand that a copy can be made available at any time upon my request.

Printed Name: ____

Signature: ____ Date: ______________________________

Relationship if under 18: ________________________________

Witness: ____ Date: ______________________________

ALLSTAR
CHIROPRACTIC

Informed Consent for Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques such as spinal adjustments are required to advise patients that there are some risks associated with such treatment.
In particular you should note the following risks, while rare, you could experience:

- Rib fractures or muscle and ligament sprains or strains following spinal adjustments:
- Injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke (sometimes with serious neurological impairment) and may on rare occasion result in serious injury.
- Disc injuries following cervical and lumbar spinal adjustment

Chiropractic treatment, including spinal adjustment, have been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches and similar symptoms. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge that I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent.

I, _____________________________, consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to my present and future chiropractic care.

Signature: ____ Date: _____________________________

Relationship if under 18: _______________________________

Dr James R DuPuy, PC: _________________________________ Date: _____________________________