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

Auto Accident Patient Acceptance Policy

AllStar Chiropractic & Wellness will accept you as a patient to treat injuries sustained as a result of an automobile accident if one of the following are true:

1. You file a claim with your own automobile insurance company. You will need to present the claim number, claim adjuster, and insurance and company information on your **first visit** so that we may bill your MEDPAY for chiropractic services as they are rendered.
   a. If MEDPAY is available to you, **it must be used** prior to billing any other insurance or 3rd party payor.

2. You provide your health insurance information. Once your claim settles, the at-fault insurance company will subrogate (pay back) your health insurance plan.

3. You provide the at-fault persons car insurance coverage. You will need to present the claim number, claim adjuster, and insurance and company information on your **first visit.**

4. If MEDPAY or PERSONAL HEALTH INSURANCE is not available, you may choose one of the following options:
   a. You may choose to retain an attorney. You must supply us with a letter of protection from your attorney by **the first** visit.
      i. You will sign a lien against any settlement you may receive as a result of your personal injury claim.
   b. You may elect to pay in full each visit and provide you with all of the documentation you would need to seek reimbursement from the at-fault party.

I have read and completely understand these policies. I also understand that I am fully responsible for my bill. If my account becomes delinquent, I will be responsible for all collection fees, interest, and court costs.

Please check the appropriate box:

☐ I will have opened a MEDPAY claim with my **own** insurance company.
☐ I will use my personal health insurance coverage
☐ I have retained attorney and have supplied a letter of protection.
☐ I will use the at fault insurance company for payment

Signature: ____ Date: __________________

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: ______________________________

ALLSTAR CHIROPRACTIC

General Traffic Accident Information

Date of Accident: ____________________________ Hour of Accident: ___________ AM PM
Days missed work due to accident: _____________ Date last worked: ______________

What kind of vehicle were you in when the accident occurred?

- ☐ Truck
- ☐ Car
- ☐ Motorcycle
- ☐ Other

Were you a:

- ☐ Driver
- ☐ Passenger
- ☐ Pedestrian

Total number of people in the vehicle: _______

Were you restrained? Y / N

What was the speed of the vehicle speed? _______MPH

What part of the vehicle was hit? ________________________

Was this a single car accident? Y / N

Describe accident including cause/s and surrounding circumstances: (Please be specific)

____
____

Any physical complains prior to the accident? ____

What symptoms did you feel during the accident? ____

What symptoms were felt later that day? ____

What symptoms did you feel the next day? ____

What are your symptoms today? ____

Are you aware of any congenital problems or previous illness related to this injury? ___________________

How has this accident affected you either socially or emotionally? __________________________________

If you consulted a doctor, give his/her name and diagnosis: ___________________ D.C. M.D. D.O D.D.S

Diagnosis: ____

What treatments did you receive? ____

Have you ever injured this area before? Y / N If so, when? _______________________

Have you ever been involved in any other type of accident fall, or had a broken bone, etc.? Please give a brief description.

____

Patient's Signature _______________________________________ Date ______________________

Doctor's Signature _______________________________________ Date ______________________

555 W Schrock Road, Suite F, Westerville, Ohio 43081
P. 614-891-1800 F. 614-891-8047
Email: info@allstarchiro.net

Date:__________

Insurance Company/ Attorney:

Re:

Claim Number:

I hereby authorize AllStar Chiropractic, Dr. James DuPuy, D.C. to furnish ______________________with a full report of his examination, diagnosis, treatment, prognosis, etc., for myself in regard to the accident in which I was involved on ________________.

I hereby authorize and direct ___________________ to directly pay AllStar Chiropractic, Dr. James DuPuy, such sums as may be due and owing him for his professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement, or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement, or verdict which may be paid to my attorney and/or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to AllStar Chiropractic, Dr. James DuPuy, for all professional bills submitted by him for service rendered me and that this agreement is solely for said doctors additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

____ ____________________
Patient Signature Date

____ ____________________
Witness Date