Information about Possible Risks of Treatment

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatment for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately 1 per 400,000 to 1 per 2 million treatments.
*Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.
*As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries of physiotherapy burns. These are extremely rare occurrences.

_____	_____	_____
Signature of Patient or Responsible Party	Date	Relationship to Patient

Payment Agreement

I, _____ understand that since I was involved in a automobile accident, workers compensation injury, or personal injury that my auto accident, work comp, or personal injury insurance will pay my medical bills that include my chiropractic bill here at Lecy Chiropractic PC. Sometimes they have a max amount that they will pay, and this may run out before my treatment plan has ended. If this situation should arise, we will bill you personal health insurance if applicable. If the health insurance doesn't cover the outstanding balance, you will be responsible for the remaining balance. If you don't have personal health insurance, you will be responsible for the remaining balance.

_____ _____

Signature Date

Lecy Chiropractic, P.C.
Patient Information Sheet

Name _____
First Middle Initial Last Preferred Name

Address: _____
Street City State Zip

Select Race:
❍ Caucasian ❍ African American ❍ Native American ❍ Asian ❍ Hispanic
❍ Other_____

Sex: ❍ M ❍ F Date of Birth: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

❍ Married
❍ Single
❍ Divorced
❍ Widowed

Work Address: _____
Street City State Zip

Email Address: _____

Spouse or Parent's Name _____ Date of Birth: _____

Referred to this office by: _____

Area of Complaint: ❍ Neck ❍ Upper Back ❍ Lower Back ❍ Other: _____

Mark the appropriate coverage: ❍ Cash ❍ Insurance ❍ Medicare ❍ Medicaid/Title 19
❍ Automobile Accident ❍ Worker's Comp ❍ Personal Injury

PAYMENT POLICY

It is the policy of this office that payment be made at the time of service for all services rendered. If desired, please ask for an estimate of fees before beginning treatment. If you are unable to pay at the time of your visit, please talk with the receptionist to make financial arrangements. I have read the above policy, and agree that I am financially responsible for all charges incurred at this clinic. **Initials**_____

INSURANCE ASSIGNMENT

We will automatically submit your insurance claims to your primary carrier, unless other arrangements are made. I hereby instruct and direct my insurance company to pay, by check made out and mailed directly to Lecy Chiropractic, P.C., the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original. **Initials**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of privacy practices is available at front desk upon request. **Initials**_____

TELEPHONE CALLS

According to HIPAA policy, Lecy Chiropractic, P. C. must have your permission to call your home. Please initial if you give the doctors and staff of Lecy Chiropractic, P. C. permission to call your home regarding your health or appointments. **Initials**_____

Signature of Patient or Parent/Guardian _____ **Date** _____

Lecy Chiropractic, P.C., 1406 Mt. Rushmore Road, Rapid City, SD 57701, (605) 343-7440, FAX 342-7868

IRREVOCABLE ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS, HEALTH INSURANCE, AUTO -MEDICAL PAYMENTS, 3RD PARTY PAYOR AND/OR ATTORNEY

I,_____, hereby authorize and direct you, my insurance company, 3rd party payor and/or my attorney, to **pay directly to Lecy Chiropractic,** any and all sums as may be due and owing me for services rendered to me by Lecy Chiropractic, both by reason of accident or illness, and by reason of any other bills that are due this office. I further direct my insurance company, 3rd party payor and/or my attorney to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, 3rd party payor benefits, or any other insurance benefits and/or monies received and/or owing me from any payments received from any settlement, judgment or verdict on my behalf in an amount equal to any outstanding balance that is owed to Lecy Chiropractic for my treatment. I hereby further irrevocably assign to Lecy Chiropractic any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Lecy Chiropractic, said assignment to be equal to any outstanding balance owed by me to Lecy Chiropractic. This is to act as an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in an amount equal to any outstanding balance owed by me to the Lecy Chiropractic. This said assignment is binding under South Dakota Codified Law (SDCL) 57A-9, SDCL 57A-9-102(46) and SDCL 57A-9-309 (5).

In the event my insurance company, 3rd party payor or attorney are obligated to make payments to me for compensation of any claims, benefits, money owed, settlements and /or judgments, and the insurance company, 3rd party payor, attorney or any other party so obligated refuses to make such payments either upon demand by me or Lecy Chiropractic, I hereby assign and transfer to Lecy Chiropractic any and all causes of action that I might have or that might exist in my favor against such company and/or party, and authorize Lecy Chiropractic to prosecute said cause of action either in my name or in Lecy Chiropractic name. I further authorize Lecy Chiropractic to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

In the event I, my attorney, heirs, attorney-in-fact or any other person acting on my behalf, receives monies owed me for compensation of benefits, claims, money owed, settlements and /or judgments, I further agree that an amount equal to that which is owed to Lecy Chiropractic by me for any treatment that I receive, shall be placed in trust for the benefit of Lecy Chiropractic, for which trust I or anyone that I so designate to be trustee, and Lecy Chiropractic being the beneficiary. Said trust will be dissolved upon all amounts due and owing Lecy Chiropractic being paid to Lecy Chiropractic.

I understand that I remain personally responsible for the total amounts due to Lecy Chiropractic for their services. I further understand and agree that this Assignment and Authorization do not constitute any consideration for Lecy Chiropractic to await payments and that they may demand payments from me immediately upon rendering services at their option.

I authorize Lecy Chiropractic to release any information pertinent to my case to any insurance company, including 3rd party payor, adjuster or attorney to facilitate collection under this Assignment and Authorization. I agree that Lecy Chiropractic shall be given the Power of Attorney to endorse and/or sign my name on any and all checks for payment of any outstanding bill owed Lecy Chiropractic.
I further understand and agree, that if Lecy Chiropractic must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse Lecy Chiropractic for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.
I also understand that interest will be charged on all balances 60 days past due.

I further direct that this Authorization and Assignment shall be binding upon my legal heirs, successors, assignees, legatees or any other party legally acting on my behalf.

Patient's Signature X _____ SS# _____ Date: _____

Guardian or Spouse's
Signature Authorizing Care _____ Date: _____

HIPAA Approved Contacts

Please list the individuals you give permission to have access to and discuss your protected health information:

NAME	Date of Birth	Phone #	Relationship
_____	___/___/___	(___) ___ - ___	_____
_____	___/___/___	(___) ___ - ___	_____
_____	___/___/___	(___) ___ - ___	_____
_____	___/___/___	(___) ___ - ___	_____

This form will remain in effect until a written request is received to change or an updated form is filled out by you.

_____ _____

Patient/Legal Guardian Signature Patient Name

_____

Date