LAFAYETTE HILLTOP CHIROPRACTIC CENTER
DR. MARY JEAN NEGRI, R.N., D.C.
DR. KRISTIN SOEHL, D.C.

23 Route 15
Lafayette, NJ 07848
Telephone: (973) 579-1608
Fax: (973) 579-7408

Patient _____

Our records indicate that you have been involved in a motor vehicle accident. In order to process your claim, please obtain the following information from your automobile insurance company. Your insurance carrier can be contacted by telephone. Please return completed form to our receptionist during your next visit. THANK YOU!

Insurance Company Name _____

Billing Address _____

_____

Telephone Number _____

Claim Adjustor's Name _____

Claim Number _____

Deductible Amount _____

Claims Paid at 100% or 80% _____

Date of Accident _____

Name of Policyholder _____

Policy Number _____

Any other information that may assist us when submitting claim for payment

_____

_____

_____

_____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

– O V E R –

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

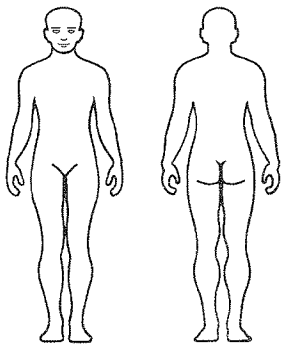
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

ATTORNEY LIEN AND RELEASE

For Patient:

TO:

FROM:

I, the undersigned, hereby authorize the above named doctor to release to you, my attorney, all information in my medical records as they relate to the accident in which I was involved.

Further, I authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for professional services rendered me both by reason of this injury and by reason of any other sums that are due his office for services rendered to me. You are hereby directed to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor and satisfy such sums.

Further, I hereby 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 you, my attorney, or myself as the result of the injuries I sustained in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all sums due him for services rendered to me and that this agreement and assignment is made solely for the doctors additional protection and in consideration of his awaiting payment. I understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover such fees.

I further direct that a facsimile or copy of this agreement shall carry equal authority as does the original.

DATE _____ SIGNATURE OF PATIENT _____

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all terms and understandings stated hereinabove and pledge to withhold such sums from any settlement, judgement or verdict as may be necessary to protect the above referenced doctor and to remit such sums directly to him.

DATE _____ SIGNATURE OF ATTORNEY _____

ATTORNEY: Enclosed are two copies of this agreement and a return envelope. Please expediently date, sign and return one copy to the doctor's office listed above. Keep one copy for your files.

PROVIDER NAME:_____ PROVIDER ADDRESS:_____
PATIENT:_____ INSURED:_____ D/A:_____
INSURANCE CARRIER:_____ POLICY No.:_____ CLAIM No.:_____

ASSIGNMENT OF BENEFITS

I, _____ HEREBY ASSIGN ALL OF MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY _____, (HEREINAFTER REFERRED TO AS "PROVIDER").

I EXPRESSLY AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION REGARDING MY BENEFITS UNDER ANY AND ALL INSURANCE POLICY'S RELATING TO ANY CLAIMS BY PROVIDER TO BE RELEASED TO PROVIDER, WHICH INFORMATION SHALL INCLUDE, BUT SHALL NOT BE LIMITED TO PAYMENT INFORMATION AND, SPECIFICALLY INFORMATION PERTAINING TO POLICY LIMITS AND AVAILABLE FUNDS. I AUTHORIZE PROVIDER TO FILE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME AND DIRECT THAT ALL PAYMENTS FOR SUCH SERVICES GO DIRECTLY TO PROVIDER.

I AUTHORIZE PROVIDER TO ACT ON MY BEHALF AND TO REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE APPROPRIATE REGULATORY AUTHORITIES.

I AUTHORIZE PROVIDER TO OBTAIN COUNSEL AND TO INSTITUTE LEGAL OR OTHER ACTION ON MY BEHALF AND/OR IN MY NAME, INCLUDING THE ARBITRATION/DISPUTE RESOLUTION PROCESS, TO COLLECT SUCH SUMS DUE AND OWING, SHOULD SUCH SUMS NOT BE PAID AS REQUIRED BY LAW AND/OR CONTRACTUAL OBLIGATIONS AND WITHIN THE LEGALLY PRESCRIBED TIME PERIOD.

IN THE EVENT PROVIDER ELECTS TO BRING A LAWSUIT OR PETITION FOR ARBITRATION/DISPUTE RESOLUTION AGAINST THE INSURANCE CARRIER, I HEREBY ASSIGN MY RIGHTS, TITLE AND INTEREST UNDER THE MEDICAL EXPENSE BENEFITS AND/OR PIP SECTION OF ANY INSURANCE POLICY UNDER WHICH I AM ENTITLED TO PROCEED FOR BENEFITS. THIS ASSIGNMENT SHALL EXPRESSLY ALLOW AN ATTORNEY OF PROVIDER'S CHOOSING TO BRING SUIT OR SUBMIT TO ARBITRATION /DISPUTE RESOLUTION THEIR CLAIMS FOR ANY UNPAID BILLS FOR SERVICES RENDERED TO ME FOR INJURIES THAT I SUSTAINED IN THIS OR IN ANY OTHER ACCIDENT.

IN THE EVENT THAT THIS ASSIGNMENT IS VOIDED FOR ANY REASON, ESPECIALLY FOR FAILURE TO APPEAL, I HEREBY AUTHORIZE PROVIDER TO APPOINT AN ATTORNEY OF ITS CHOOSING TO REPRESENT ME DIRECTLY AGAINST ANY INSURANCE COMPANY FROM WHICH I MAY COLLECT PIP BENEFITS, AND TO BRING A CLAIM IN THE FORUM OF IT'S CHOICE.

I UNDERSTAND AND ACKNOWLEDGE THAT THIS PROVISION SHALL SERVE TO REVOKE MY ASSIGNMENT TO THE PROVIDER, AND RENDER MY ASSIGNMENT NULL AND VOID—THIS PROVISION SHALL NOT, HOWEVER, SERVE TO PRECLUDE THE ATTORNEY CHOSEN BY THE PROVIDER FROM PURSUING A LEGAL ACTION IN MY NAME AND ON MY BEHALF WHETHER BY WAY OF SUIT, OR BY ARBITRATION/DISPUTE RESOLUTION. THIS PROVISION IS EXPRESSLY INTENDED TO ENABLE THE ATTORNEY TO COLLECT THE BILLS OF PROVIDER DIRECTLY IN MY NAME.

I HEREBT ACKNOWLEDGE THAT I MAY RECEIVE BENEFIT CHECKS DIRECTLY AND PAYABLE TO ME.

I HEREBY AGREE TO IMMEDIATELY ENDORSE SUCH BENEFIT CHECKS TO THE PROVIDER AND TO IMMEDIATELY FORWARD THE SAME TO THE PROVIDER UPON MY RECEIPT.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE VALID AS THE ORIGINAL.

I HAVE READ THIS ASSIGNMENT AND IT HAS BEEN EXPLAINED TO ME, AND TO MY FULL SATISFACTION, AND I FULLY UNDERSTAND ITS NATURE AND EFFECT.

_____ DATED:_____

PATIENTS SIGNATURE

LAFAYETTE HILLTOP CHIROPRACTIC CENTER
DR. MARY JEAN NEGRI, R.N., D.C.
DR. KRISTIN SOEHL, D.C.

23 Route 15
Lafayette, NJ 07848
Telephone: (973) 579-1608
Fax: (973) 579-7408

AUTHORIZATION TO PAY DOCTOR AND RELEASE MEDICAL INFORMATION

To Whom It May Concern:

I _____ hereby authorize payment directly to Lafayette Hilltop Chiropractic Center, Mary J. Negri, D.C. or Kristin Soehl, D.C. for professional services rendered. I shall be personally responsible for any unpaid balance to the Doctors.

I _____ hereby authorize Lafayette Hilltop Chiropractic Center, Mary J. Negri, D.C. or Kristin Soehl, D.C. to release any information concerning my examination or treatment.

I _____ hereby authorize any medical facility, organization or insurance company to furnish my records, information, x-ray report in their profession to Lafayette Hilltop Chiropractic Center, Mary J. Negri, D.C. or Kristin Soehl, D.C.

Insured Patient _____ SS# _____

Date: _____ Date of Birth: _____

A PHOTOCOPY OF THIS ASIGNMENT SHOULD BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Lafayette Hilltop Chiropractic Center
23 State Route 15
Lafayette, NJ 07848
973-579-1608

Patient Name_____ Date_____

Patient Address_____

City_____ State_____ Zip Code_____

Home Phone #_____ Work Phone#_____ Cell#_____

E-mail address_____ Date of Birth_____

Patient Occupation_____ Social Security#_____

Patient Employer_____

Primary Health Insurance Plan_____

Name of Insured (if other than you)_____

Relation to Patient_____ Insured DOB:_____

Secondary Health Insurance_____

Name of Insured (if other than you)_____

Relation to Patient_____ Insured DOB:_____

Do You Currently Have a Health Savings Account?_____

Referred for Treatment by_____

Lafayette Hilltop Chiropractic Center

Patient's Name: _____ **Birth Date**_____ **Date:**_____

What Is Your Current Complaint:_____

_____

_____

Date of Onset: _____

Location: _____ **Severity**_____
Where is the problem scale of 1-10 10 Being MOST SEVERE

What Caused Your Problem: accident, injury or no specific reason_____

_____

How Would You Describe Your Pain: circle all that apply;
Sharp Soreness Throbbing Tingling Dull Stiffness
Spasm Burning Numbness Weakness Ache Shooting

How Often Is It Present:
Constant (81-100%) ☐ Frequent (51-80%) ☐

Occasional (26-50%) ☐ Intermittent (25% or less) ☐

What Makes It Better: circle all that apply
Nothing Walking Standing Sitting Moving/Exercise Lying down Inactivity

What Makes It Worse: circle all that apply
Nothing Walking Standing Sitting Moving/Exercise Lying down Inactivity

Were You Previously Treated For this Condition: Yes No
If yes, by whom? MD Chiropractor Physical Therapist Other

Present Medical Doctors	Medications/Vitamins
_____	_____
_____	_____
_____	_____

Have You Ever Been Hospitalized:
List dates and reasons

_____
_____
_____

Have You Ever Had Surgery:
list dates and type of surgery

_____
_____
_____

Have You ever been involved in a motor vehichle accident: Yes No
Describe how the accident occurred_____

_____

_____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Past or Present Symptoms, Conditions, or Habits

Below is a list of symptoms, conditions, or habits. Please check all that apply

Symptom	Past	Present	Symptom	Past	Present
Neck Pain	☐	☐	High Blood Pressure	☐	☐
Shoulder Pain	☐	☐	Heart Condition	☐	☐
Arm/elbow Pain	☐	☐	Respiratory Condition	☐	☐
Hand Pain	☐	☐	Digestive Problem	☐	☐
Upper Back Pain	☐	☐	Kidneys/Bladder Problems	☐	☐
Lower Back Pain	☐	☐	Menstrual Problems	☐	☐
Upper Leg or Hip Pain	☐	☐	Breast Soreness/lump	☐	☐
Lower Leg or Knee Pain	☐	☐	Sinus Condition	☐	☐
Ankle or Foot Pain	☐	☐	Allergies/Asthma	☐	☐
Jaw Pain	☐	☐	Cancer	☐	☐
Swelling/stiffness of joints	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Excessive weight loss or gain	☐	☐
Dizziness	☐	☐	Skin Condition	☐	☐
Fainting Spells	☐	☐	Arthritis	☐	☐
Convulsions	☐	☐	Diabetes	☐	☐
General prolonged fatigue	☐	☐	Prostate	☐	☐
Condition of Uterus/Ovaries	☐	☐			

Tobacco Use:
☐Past ☐Present ☐Occasional
☐Moderate ☐Heavy

Alcohol Use:
☐Past ☐Present ☐Occasional
☐Moderate ☐Heavy

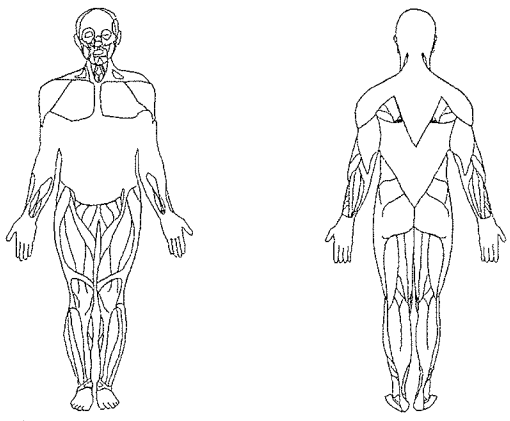
Caffeine Use: (coffee, tea, soft drinks)
☐Past ☐Present ☐Occasional
☐Moderate ☐Heavy

Pregnancy:
☐ Past ☐ Present

Birth Control Pills: Yes No

Comments: _____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date

Lafayette Hilltop Chiropractic
23 Route 15
Lafayette, NJ 07848

PATIENT COMMUNICATION CONSENT FORM

TEXT MESSAGE ALERTS

I authorize Lafayette Hilltop Chiropractic Center to send text message appointment reminders to me on my provided cell phone number. I understand that I may receive account information such as future appointments, office location and other alerts as described in our text message and/or email message. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply.

Account Guarantor's Cell Phone: (_____) _____

Account Guarantor's Email Address: _____

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the account(s), that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text and email messaging services. I understand that this authorization can only be revoked in writing.

_____ _____
Signature Date

It is important to note that text and email communication is not always secure. Text and email messages can be intercepted and for this reason, we do not communicate personal health information through this method. Complete terms and conditions can be requested from office staff.

Lafayette Hilltop Chiropractic Center
23 Route 15
Lafayette, NJ 07848

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

Lafayette Hilltop Chiropractic Center
23 Route 15
Lafayette, NJ 07848

Informed Consent -- Chiropractic Care

Dr. Mary Jean Negri, R.N., D.C.

Patient's Name: _____

Date of Care Plan: __/__/__ (see attached Care Plan)

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____

Date of Signature: ___/___/___

Lafayette Hilltop Chiropractic Center

DISCLOSURE OF INSURANCE PARTICIPATION

STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

SECTION ONE: HEALTH PLANS LAFAYETTE HILLTOP CHIROPRACTIC PARTICIPATES WITH:

Dr. Mary Jean Negri, R.N., D.C. presently participates with the following health insurance plans:

1. NONE

If your health plan is not listed above in this Section One, your surgeon does not participate with your health plan. In order to proceed with any health care services, you, the patient, must complete, sign and date this form.

SECTION TWO: HOSPITALS LAFAYETTE HILLTOP CHIROPRACTIC IS ASSOCIATED WITH:

Dr. Mary Jean Negri, R.N., D.C. presently has privileges at the following hospitals to perform surgical procedures:

1. NONE

Please contact your health plan or the hospital at which you are to receive services to determinethe participation status of the hospital, other providersand services the hospital is affiliated with, and associated cost obligations for you, the patient, prior to booking your procedure.

SECTION FOUR: LICENSED ASSISTANT HEALTHCARE STAFF:

The following licensed healthcare professionals may perform assistant services on you, the patient, based upon the treatment plan and needs of the patient:

1. Jessica Stonebridge
   23 State Route 15 Lafayette, NJ 07848
2. Elaine Stephens
   23 State Route 15 Lafayette, NJ 07848
3. Rose Locker
   23 State Route 15 Lafayette, NJ 07848
4. Kimberly Spooner
   23 State Route 15 Lafayette, NJ 07848
5. Christine McCormack
   23 State Route 15 Lafayette, NJ 07848

SECTION FIVE: ANESTHESIA, RADIOLOGY, LABORATORY, PATHOLOGY SERVICES:

The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

1. NONE

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/ or pathology services may **not** participate with any health insurance plans and may be "out-of-network" providers subject to the following disclosures. Patient should inquire with each provider to determine their participation status and/or contact patient's health plan or administrator for further consultation on costs associated with these services.

cont'd.

SECTION SIX: MANDATORY DISCLOSURES & PATIENT ACKNOWLEDGMENT:

1. I understand that the chiropractor that I am seeking healthcare services from is "out of-network" with anddoes not participate with my health insurance plan;

ⓧ _____
Patient's Initials

2. I understand that the amount or estimated amount the chiropractor will bill me, the covered person,or my health plan, for the services is available upon request;

ⓧ _____
Patient's Initials

3. I may request from the chiropractor an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the surgeon shall disclose to me, the patient, in writing, the amount or estimated amount that the surgeon will bill me, the covered person, or my health plan, for the service and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

ⓧ _____
Patient's Initials

4. I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, that may be in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan; and

ⓧ _____
Patient's Initials

5. I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

ⓧ _____
Patient's Initials

The chiropractor and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient, under the law.

The chiropractor further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takesplace, the network status of the surgeon or any of the health care professionals listed in this disclosure change as it relates to the patient's health benefits plan, the chiropractor shall notify the patient promptly.

SECTION SEVEN: ACKNOWLEDGEMENT OF RECEIPT OF DISCLOSURES

I, the undersigned patient, acknowledge receipt of this disclosure form from my surgeon, and have read it and understand the contents. I have discussed my option to obtain treatment with other chiropractors, health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so andwish to obtain my treatment with this chiropractor with full notice of these disclosures and potential cost sharingconsequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not beingcoerced to sign this disclosure, and do so upon my own free will.

_____
By

_____
Print Name

_____
Date