Your Family Chiropractor

Dr. Tom K. Jensen
5011 S. Bur Oak Place ~ Sioux Falls, SD 57108
(605) 371-3346

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the information below and if you have any question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Your Family Chiropractor, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There will be a $20 fee charged for all appointments that are missed or canceled within three hours of the scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

I, _____, have read and fully understand the above statements.

Acknowledgement

I have received the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____

IRREVOCABLE ASSIGNMENT OF HEALTH-CARE INSURANCE RECEIVABLES
UNDER ARTICLE 9 – SECURED TRANSACTIONS –
UNIFORM COMMERCIAL CODE (SDCL CHAPTER 57A-9) and
AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION

TO: _____
(name of insurance company/attorney)

I, the undersigned, do hereby irrevocably assign, set over and grant a perfected security interest pursuant to the provisions of SDCL 57A-9 **To Your Family Chiropractor** in and to any and all health-care insurance receivables due the undersigned as a result of health-care services provided me by the above named doctor or clinic by reason of accident, illness or any other health related condition. This is an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in the amount equal to any outstanding balance owed by me to the above named doctor or clinic.

In the event my insurance company or any other party obligated to make payments to me refuses to make payment upon demand by me or the above named doctor or clinic, I hereby assign and transfer to said doctor or clinic any and all causes of action I may have now or in the future against said party and do hereby authorize said doctor or clinic to prosecute said cause of action in my name or the name of said doctor or clinic and to compromise, settle or otherwise resolve such claim or cause of action.

I understand that I remain personally liable for all amounts due said doctor or clinic and that this Assignment and Authorization does not constitute consideration for said doctor or clinic to await payment and that the same may demand payment immediately upon rendering service and may charge interest at 15% per annum (compounded daily) on all balances after 30 days. If said doctor or clinic must take any collection action, I will be liable for all costs of collections actions, including court costs and reasonable attorney fees.

I authorize the above named doctor or clinic to release any records or information regarding my treatment to any insurance company, third party payor or attorney to facilitate collection of all benefits due me under this Assignment and Authorization and further authorize them to endorse on my behalf all checks and drafts issued to me, in my name or for my benefit.

This Assignment and Authorization shall be binding upon my legal heirs, personal representative(s), successors and assigns and any other person legally acting on my behalf.

Patient's Signature _____ SS#_____-___-_____ Date:_____

Signature of Parent, Spouse or Guardian Authorizing Care_____
Date: _____