

PATIENT REGISTRATION:

Please print

Date _____ How did you know about our office? _____
Where did you find our phone number? _____
Primary Care Physician _____

If a friend or family member referred you, may we send them a thank you? YES NO

Patient Name : _____ Age _____

Address _____ Apt # _____

City _____ State _____ Zip _____

1-Home # _____ 2-Work # _____
3- Mobile # _____ BEST contact # 1 2 3

Date of birth _____ SS # _____
Male/Female _____ Married/ Single/ Divorced/ Widowed _____ Student? Y N

Employer _____ Phone _____ Contact person _____
Email: _____ for reminders and office / holiday hours

Primary Insurance? Yes No Secondary Insurance? Yes No Tertiary Insurance? Yes No
Name of insured _____ DOB _____ SS# _____
Employer providing insurance _____

Accident related to employment (on-the-job)? Yes No Motor vehicle accident? Yes No

Emergency? Yes No Date complaints began _____

Name of spouse _____ Contact phone # for emergency _____

Name of other nearest relative or friend _____ phone _____

FINANCIAL RESPONSIBILITY*: You are responsible for any charges/money due for services supplied by this office as part of any/all management of your treatment and healthcare. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE.

****THERE WILL BE A \$30 nsf FEE FOR ANY RETURNED CHECKS ****

**** YOU WILL BE RESPONSIBLE FOR ANY AND ALL LEGAL FEES OCCURRED WHILE ATTEMPTING TO COLLECT OUTSTANDING BALANCES ****

I understand and agree to the previous disclaimer:

Signature _____

CONSENT FOR TREATMENT

The nature of the Chiropractic adjustment. The primary treatment used at Crossroads Chiropractic is the spinal adjustment. We will use that procedure to treat you. We will use our hands or a mechanical device upon your body in such a way as to move your joints. That may cause you to hear a "pop" or "click" much as you might have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in Chiropractic adjustment.

As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. 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.

The probability of those risks occurring.

Any type of complication is very rare and generally results from some underlying weakness of the bone, which we check for during the taking of your history and during the examination and x-ray. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury.

By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to Crossroads Chiropractic to perform the treatment and acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given to me.

[] I authorize Dr. Elizabeth Taylor to administer treatment as deemed necessary to treat my problem / condition.

ASSIGNMENT OF BENEFITS: Should any member of Elizabeth R. Taylor, D.C., President, dba Crossroads Natural Health, LLC, accept third party reimbursement for all or part of her professional fees, I hereby assign benefits and authorize the carrier or attorney to make payment directly to Elizabeth R. Taylor, D.C. I understand that any remaining balance after said payment will be my responsibility as the sole party responsible for payment.

RELEASE OF MEDICAL RECORDS: I hereby authorize Elizabeth R. Taylor, D.C., dba Crossroads Natural Health, LLC, to disclose to my attorney, third party carriers or agents, and my treating doctor or his/her agents with any and all medical information and related fees relative to my condition, care and treatment as needed to determine benefits payable in connection with this injury.

_____ **patient's name - print**

_____ **patient's name - signature**

date of injury: _____

SS# _____

date of birth: _____

date signed _____

witness: _____

Dr. Taylor _____

Crossroads Natural Health, LLC

Dr. Elizabeth Taylor, Chiropractor

3125 -B S. Carrier Pkwy. 75052

P.O. Box 540369 75054-0369

972.641.7111

Grand Prairie, TX

972.660.1119 fax

PRIVACY NOTICE AGREEMENT

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment and healthcare operations.

With my signature below, I give consent for Crossroads Chiropractic, Wellness and Pain Management (the Practice) to use and/or disclose information about me (or for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and healthcare operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy by request.

I have the right to request restrictions on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me including any invoices for services, reminder cards, birthday cards, newsletters, and the like, at the address/phone number/fax number/email address designated in my registration forms.

Patient / Representative

_____/_____/_____
Date