BODY ELEMENTS CHIROPRACTIC AT ENCORE
believe in better! believe you deserve it!
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Minor Sign In

WELCOME TO BODY ELEMENTS CHIROPRACTIC

Child's name:	Date:		
Child's age:	Child's Date of Birth (DOB):		
Mother's name:	Father's name:		
Mother's occupation:	Father's occupation:		
Referred by:	Best email to contact:		
Cell home:	Home phone:		
Address:	City:	State:	Zip:
Names / Ages of other children:			
Emergency contact name and relation:		Phone:	

Primary Health Insurance Info*		
Insurance Co. Name:		Phone:
Insurance Co. Address:		
Insured Name:	Insured Relationship to Patient:	
Insured DOB:	Insured ID/Claim #	Group #

Secondary Insurance Health Insurance Info		
Insurance Co. Name:		Phone:
Insurance Co. Address:		
Insured Name:	Insured Relationship to Patient:	
Insured DOB:	Insured ID/Claim #	Group #

Accident Inquiry		
Is this visit due to an accident? □Sport Injury □Motor Vehicle Accident □Other Injury □NA		
Is there currently a claim or lawsuit open or pending regarding this injury? □Yes □ No		
If yes, please provide the name and phone number to your attorney:		
Responsible party for the accident:	Was the child: □ In front □In back □Other:_____	
Insurance of the person responsible for the accident	Company:	Policy #:
Accident Claim#:		
Your car insurance policy # (PIP, Personal Injury Protection):		
Your car insurance company and contact info:		

* Please note that I have elected to be practice as an out of network practitioners with all insurance companies. All payments are due at the time of service. As a courtesy, I can offer contacting your insurance to help understand your coverage and benefits to make it easier for you to navigate how to get reimbursed.

TERMS OF ACCEPTANCE
I understand and agree that Doctor Zaré has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Please Initial _____ Patient / Legal Guardian

ASSIGNMENT, AUTHORIZATION
I hereby consent to a chiropractic evaluation and examination, sEMG, Thermography, PWP (Heart Rate Variability) scan, chiropractic treatment(s), supplements, healthy lifestyle information (books, CD's, DVD's etc), activities of daily living information or laboratory procedures rendered to the client which Dr. Zaré may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Body Elements Chiropractic. I hereby authorize Dr. Zaré to release information requested on this form and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment.

Please Initial _____ Patient / Legal Guardian

FEDERAL HIPAA PRIVACY RULE CONSENT FORM
By signing this form, you are giving Dr. Zaré permission to use and disclose your protected health information for the purposes of treatment, payment, and healthcare operations. A copy of our Notice of Privacy Practices may be obtained from the internet or website. Please note, however, that our Notice of Privacy Practice may be changed as needed to comply with Federal Law.

Please Initial _____ Patient / Legal Guardian

PHILOSOPHICAL AGREEMENT
I hereby agree and understand that health is a state of optimal physical, mental and social wellbeing, not merely the absence of disease. I understand that Dr. Zaré does not offer diagnosis or treatment for specific diseases. Dr. Zaré's practice objective is to eliminate interference to the expression of the body's innate wisdom and to create an alkaline environment that supports my body to integrate, update and hold my adjustments.

Please Initial _____ Patient / Legal Guardian

TERMS AND FINANCIAL RESPONSIBILITY
I claim full financial responsibility for services rendered with Body Elements Chiropractic and Dr. Zaré will not be responsible for filing of claims required for payments of my account. I understand and agree that I am ultimately responsible for services needing pre-authorization, collection of my insurance claim of benefits, or negotiation of a settlement with my insurance company. I know I am responsible for payment of my account and I understand and agree that I am ultimately responsible for all services needing pre-authorization by my insurance and I will accept the responsibility for filing with a collection company for services that are not pre-authorized and that any balances for denied services, deductibles, coinsurances and co-pays are my responsibility to pay.

Upon request, a super bill of services rendered with all diagnosis and procedural information will be provided for you to submit to your insurance for possible reimbursements. All payments are due at the time of service. Visa/MC and Discover are accepted. Please make checks to Body Elements Chiropractic. Return check fee is $30.

Please be courteous of our time as we are with yours. A 24 hour cancellation notice is appreciated and in the case of repeated no-show incidents, we reserve the right to charge a fee of $50 for the missed appointment.

Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1.5% per month (annual percent rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

Please Initial _____ Patient / Legal Guardian

I have read the above statements and understand Body Elements Chiropractic's objectives pertaining to my care in this office.

Signature and Name: _____ Date:_____

Your health is your greatest asset. Thank you for the opportunity to serve you!