BACK-HEALTH CHIROPRACTIC INITIAL PATIENT REGISTRATION (2016)
Dr. Goudarz Vassigh, DC

PATIENT **THIS SECTION REFERS TO PATIENT ONLY**

Patient: _____ Date of birth _____ ☐ Male ☐ Female
LAST FIRST MIDDLE
Address: _____ Social Security #: _____

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children _____

Cell Phone (_____) _____ Spouse's Name: __

Home Phone: _____ Email:_____
(Email will be kept in strict confidence)
Work Phone: _____ Employer's Name: _____

Employer's Address: _____
City State Zip
In Case of emergency, notify _____ Relationship _____Phone # (_____) _____

How did you find our practice? __ Internet __ Yellow Pages __ Signage __ Patient Referral __ Staff Referral __ Care to Share Card

Who may we thank for the referral?

BILLING **COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT**

Name of Responsible Party: _____ Date of Birth _____ SS#: _____

Address: _____ Relationship to Patient: _____

City, State, Zip: _____ Employer: _____

Home Phone: (_____) _____ Address: _____

Work Phone: (_____) _____ City, State, Zip _____

As the party responsible, I agree that all charges that are not directly paid by my insurance will be my responsibility. I hereby authorize Dr. Goudarz Vassigh, DC or whomever he may designate as assistant, to administer chiropractic care as deemed necessary to my (please CIRCLE relationship to parent/guardian) _____ who is named above as patient.

Responsible Party Signature: _____

NOTE: As a courtesy to our patients, we will attempt to verify your chiropractic coverage. Please note that the information provided by your plan's customer service department to us is NOT a guarantee of coverage. It is the patient's responsibility to know and understand their benefits including the financial implications.

INSURANCE **PLEASE SUPPLLY INFORMATION FOR BOTH INSURANCE CARRIERS IF APPLICABLE**

**** Copy of Card Provided (Front & Back) Y or N
Primary Carrier Name: _____ Insured's Name: _____

Policy or ID #: _____ Insured's Date of Birth: _____

Member Services Telephone: (_____) _____ Insured's SS #: _____

Claims Mailing Address: _____
City, State, Zip

I hereby authorize payment of medical benefits to Back-Health Chiropractic for services rendered. I hereby authorize Back-Health Chiropractic to release any medical information necessary to complete and process my insurance claims.

Information taken by: _____

Patient or Guardian's Signature: _____ Date: _____

BACK-HEALTH CHIROPRACTIC

APPOINTMENT CANCELLATION POLICY

It is the client/patient's responsibility to contact our office and give us **24 HOURS** notice of any appointment cancellation **ON THE BUSINESS DAY PRIOR*** to the scheduled appointment. (i.e. if you have an appointment on a Monday you must contact us to cancel the appointment by 3pm on the Friday prior to the appointment).

***Office Hours**
Monday 9am-5pm Chiropractic/Spa
Tuesday Spa 9am-7pm Chiropractic 2pm-7pm
Wednesday 9am-5pm Chiropractic/Spa
Thursday Spa 9 am-7pm, Chiropractic 2pm-7pm
Friday 9am-12pm Chiropractic, Spa 9am-5pm
Saturday Chiropractic 1st Saturday of the month, Spa 9am-3pm

If client/patient does not notify our office 24 hours prior to scheduled appointment to cancel, they are subject to a **SAME DAY CANCELLATION CHARGE** of **$25.00.**

This is our policy. Please sign below for acceptance of the cancellation policy.

_____ _____
Acknowledgement Date

Revised 3/16

4425 N. 24th Street, Phoenix, AZ 85016
602-956-8222-t 602-956-8333-f www.backhealthaz.com

BACK-HEALTH CHIROPRACTIC **INFORMED CONSENT (03/2016)**
Dr. Goudarz Vassigh, D.C.

Patient Name: _____

The nature of the chiropractic manipulation: I will use my hands or an instrument to move the joints of your body; this may result in an audible "**pop" or "click**".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: **strains, dislocations, fractures, disc injuries and stroke**. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications are considered rare. One source states that **stroke** is a possible occurrence in 1/1,000,000 cases or higher.

Physical Therapy Recommended:	**Possible Adverse Reactions:**
▪ **Ice/Heat**	**Burn**
▪ **Muscle Stimulation**	**Burn**
▪ **Ultrasound**	**Burn**
▪ **Therapeutic Exercise**	**Sprain/Strain of Muscles & ligaments**
▪ **Neuromuscular Re-Education**	**Sprain/Strain of Muscles & ligaments**
▪ **Decompression Traction Table**	**Sprain/Strain**
▪ **Light Therapy**	**Not recommended during pregnancy**

Other treatment options for your condition include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from the procedure and the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

The patient had the following questions and was supplied the following answers:

_____

_____

_____ _____ _____ _____
Patient's Signature **Date** **Physician's Signature** **Date**

BACK-HEALTH CHIROPRACTIC

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:
(Please initial)

_____You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

_____I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

_____In the event any insurance obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I hereby assign and transfer you to the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company proceeds, whether it be all or in part of what is due, I personally owe and agree to pay you.

_____In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Arizona.

_____I agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

_____This Authorization and Assignment will be in continual effect until revoked by both parties.

_____If at the end of your treatment you are unable to meet your fiduciary responsibilities in full at time of request a payment plan can be set up for you. If no payment can be agreed upon the balance of the account will be turned over to a collection agency.

Patient Signature_____ Date_____

Revised 3.31.16

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BACK-HEALTH CHIROPRACTIC

NOTICE OF FINANCIAL ARRANGEMENT

Patient: _____

I, _____, as the Responsible Party, have been made aware of my financial responsibilities as a patient and/or patient's financial responsible party of Back-Health Chiropractic with respect to deductibles of _____, co-payment of _____, co-insurance percent's of _____ and/or cash payment arrangements of _____. Insurance companies routinely send the payment checks for billed services to the insured patient. It is the patient's responsibility to alert our office that they have received the checks and to bring those checks and explanation of benefits (EOB) to Back-Health Chiropractic within 5 days of receipt of payment,

I am unable to meet my full financial obligations with respect to my deductible, patient portion, co-insurance percentages and/or cash payment arrangements. Therefore, a financial payment arrangement has been established for my account with Back-Health Chiropractic as follows:

_____
_____
_____
_____
_____
_____
_____

for the period of _____.

_____ _____
Responsible Party's Signature Date

_____ _____
Provider Signature Date

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