

CENTENNIAL WELLNESS CENTER

7910 W. Tropical Pkwy. Ste. 110 LV, NV 89149

(T) 702.458.2225 (F) 702.396.4536

INSURANCE / MEDICARE NP FORM

PERSONAL INFORMATION

First \_\_\_\_\_ M.I \_\_\_\_\_ Last Name \_\_\_\_\_

DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender Male Female

SSN \_\_\_\_\_ Marital Status Single Married Divorced Widowed

Employed Yes / No If yes, what is your occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

How did you hear about us? Google Yelp Facebook Instagram Person \_\_\_\_\_ Other \_\_\_\_\_

CONTACT INFORMATION

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Cell # \_\_\_\_\_ Alternate # \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

CASE INFO

Due to accident Yes / No Attorney \_\_\_\_\_

Case Type Auto Accident Slip and Fall Other \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Did you go to the hospital Yes / No Where \_\_\_\_\_

Were X-rays taken Yes / No Were you transported by ambulance Yes / No

Present Medications/Conditions

Previous Surgeries and Dates

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies

Family Health History

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Payment is expected at time of visit unless prior arrangements have been made. If you have health insurance, this is a direct assignment of benefits under your policy. This means you understand any remaining balance is your responsibility.

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

INSURANCE/ATTORNEY INFORMATION

Your Attorney (if applicable) \_\_\_\_\_

Your Insurance ( if applicable) \_\_\_\_\_

ASSIGNMENT OF BENEFITS

I hereby guarantee payment of all charges incurred for services rendered to me, \_\_\_\_\_  
\_\_\_\_\_ (print name).

I also hereby assign and direct you to pay medical benefits under this claim directly to CENTENNIAL WELLNESS CENTER and/or Danielle Buda, D.C. I also hereby authorize CENTENNIAL WELLNESS CENTER and/or Danielle Buda, D.C to furnish from my records, any information requested by the insurance company in connection with the above assignment.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

WITNESS \_\_\_\_\_

# *Centennial Wellness Center*

## Doctor-Patient Relationship in Chiropractic

### Informed Consent

#### **CHIROPRACTIC**

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctors' procedures often depends on environment, underlying causes and physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

#### **ANALYSIS**

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

#### **DIAGNOSIS**

Although Doctors of Chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other options as to whether or not you should take this step, but you are responsible for the final decision.

#### **INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the Doctors of Chiropractic, gives the doctors 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 problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctors, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctors of Chiropractic provides a specialized, non-duplicating health service. The Doctors of Chiropractic are licensed in a special practice and are available to work with any other types of providers in your health care regime.

#### **RESULTS**

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

#### **TO THE PATIENT**

Please discuss any questions or problems with one of the doctors before signing this statement of policy.

I have read and understand the foregoing.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand CENTENNIAL WELLNESS CENTER Notice of Privacy Practices.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_