CIELO

SPORTS & FAMILY CHIROPRACTIC

Hands on help that's above the rest!

Date: _____

PATIENT DEMOGRAPHICS

Name_____
Address_____
City _____State_____ Zip_____
Home Number_____ Cell Number _____
Birth Date_____ Age____ Sex: M__ F__
E-Mail Address _____
Marital Status:
Single__ Married___Divorced____Other_____
Number of Children_____
Occupation_____
Work Phone_____

EMERGENCY INFORMATION

Emergency Contact_____
Relationship_____
Phone Number_____

DESIRED METHOD OF PAYMENT

- Self
- Self & Auto Insurance
- Other _____

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FEE SCHEDULE

Full payment is due when service is rendered.
*Unless other arrangements are made in advance.

INITIAL VISIT - $100.00

	Usual and Customary Cost	Patient Cost**
DIGITAL X-RAYS (per view)	$75.00	$30.00
CONSULTATION (99201)	$75.00	$30.00
ADJUSTMENT (98941)	$87.00	$40.00

CIELO MAINTENANCE PROGRAM

*TIME OF SERVICE FEE DISCOUNT

Per Visit

INDIVIDUAL **$40.00**

Cielo Sports & Family Chiropractic Centre is out-of-network with all health insurance companies. We will be happy to give you the information needed to file the claim yourself with your insurance company.

PATIENT SIGNATURE _____

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Patient Name _____

RELEASE OF INFORMATION

I hereby authorize Cielo Sports & Family Chiropractic to release medical and financial data to my insurance and attorney.

INITALS _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and service rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not the insurance company. Cielo Sports & Family Chiropractic can not accept total responsibility for collection an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures.

INITALS _____

CONSENT FOR TREATMENT OF A MINOR

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of Cielo Sport & Family Chiropractic. The undersigned states that he/she is the patient's legal guardian.

INITALS _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to Cielo Sport & Family Chiropractic for professional services rendered. **NO OTHER THIRD PARTY**, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office.

INITALS _____

TERMS OF ACCEPTANCE

I understand that chiropractic **IS NOT** the diagnosis or treatment of disease. I understand that chiropractic **CAN NOT** cure or fix me. The chiropractors sole purpose is finding nerve interference in my body, known as VERTEBRAL SUBLUXATION, correcting or reducing the interference, so that my body can heal, regulate and function optimally once more. I accept care on this premise.

INITALS _____

X-RAY WAIVER

I AUTHORIZE Dr. Todd Cielo, and Cielo Sport & Family Chiropractic, to adjust my spine **WITHOUT** having seen my x-rays. I understand that it is important for them to have a clear image of my spine and will not hold them responsible for anything they can not see.

INITALS _____

I have read and understand these terms of acceptance.

Patient, Agent or Representative | Relationship | Date

Cielo Sports & Family Chiropractic Centre

Patient Consent
For use and/or disclosure of protected health information
To carry out treatment, payment and healthcare operations

_____ hereby states that by signing this consent, I acknowledge and agree as follows:

The Practice's Privacy notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: a postcard mailed to me at the address provided by me; and telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by email.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Patient/Individual (Please print) Signature of Patient/Individual

Date_____

Patient Name:_____

Dr. Todd J. Cielo
Cielo Sports & Family Chiropractic
3710 W. Euclid Ave.
Tampa, FL 33629

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

-The nature of the chiropractic adjustment.

Spinal joints that are locked up, fixated, or not moving properly can irritate nerves that are in a close proximity. Chiropractic adjustments add motion to these areas. I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. This helps restore nervous system integrity and can improve the healing process.

-The material risks inherent in chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. 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. The other complications are also generally described as "rare."

-Ancillary treatment.

In addition to chiropractic adjustments, I intend to use the following treatments:

Stretching and icing the areas of concern relating to the patient's injuries.

-The risks and dangers attendant to remaining untreated.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

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 that treatment.

Dated:_____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)