Welcome to Sportif Chiropractic

Patient Information

Today's Date:_____

First Name: _____ MI____ Last Name_____
Address_____
City/State/Zip_____
Social Security#_____ Male___ Female___
Marital Status: Single___ Married___ Spouse Name: _____
Date of Birth: _____ Home Phone_____ Cell_____
Emergency contact name and phone_____

Insurance Information:
Please provide your insurance card and identification

Insurance Co. Name: _____Phone:_____
Policy number/SS# _____
Primary policyholder's name: _____
Primary policyholder's birth date: _____
Primary policyholder's relationship to patient: _____
Secondary ins. Co. name (if applicable) _____Phone:_____
Policy Number/SS#_____
Policyholder's name: _____
Policyholder's birth date: _____
Policyholder's relationship to patient: _____

Employers Information:

Employers Name: _____
Address: _____City/State/Zip: _____
Phone Number: _____

Important:

Is your visit today due to a motor vehicle accident? YES____ NO_____
If yes, Date of accident: _____

Is your visit today due to a work-related accident? YES_____ NO_____
If yes, Date of injury: _____

Sportif Chiropractic Dr. Tony Vu, D.C.
10595 Discovery Dr. Ste. 3 Las Vegas, NV. 89135 P. 702-877-1200 F. 702-877-9940
sportifchiro@gmail.com

Welcome to Sportif Chiropractic

Patient Information Continued

Describe your pain and its location:

_____

_____

_____

_____

Cause of injury:

_____

_____

_____

_____

History of previous injuries and surgeries:

_____

_____

_____

_____

Attorney Information (If accident related):

Attorney Name: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Patient Signature: _____

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If Sportif Chiropractic is billing your insurance company for services, please read the following:

It is important that you respond to any and all correspondences you may receive from your insurance company. Please be aware that most insurance companies have rules and regulations regarding payment of claims and all claims are pending payment until the requested information has been returned. Please do NOT ignore their requests!

Be advised that if you fail to cooperate with their requests, your claims are at risk of being unpaid. If this occurs, you will become 100% responsible for your outstanding bill. To avoid this inconvenience, a quick response to any request is advised.

I have read this information and agree to its terms.

_____ _____

Patient Signature Date

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the patient named below) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic. I have had the opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of a chiropractic adjustment and/or other procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts known, and is my best interest. I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient Name: _____

Signature of Patient: _____

Date: _____

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HIPPA NOTICE:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. 1. The patient understands and agrees to allow Sportif Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. 2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. 3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. 4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. 5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions known by Sportif Chiropractic to assure that your records are not readily available to those who do not need them. 6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures. 7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patients Signature: _____Date:_____

Spouse's or Guardian's Signature: _____Date:_____

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