7a

CONTACT INFORMATION

Date _____

Patient name (please print) _____

E-mail address _____

Please list any phone numbers that we have permission to use to confirm your appointments,
Put a check mark next to the phone number to call first.

Home (____) _____

Work (____) _____

Cell (____) _____

Other (____) _____

I realize that reminder calls are done as a courtesy. Ultimately, it is my responsibility to know my appointment date and time. I am aware that any missed appointments could result in an office visit charge.

_____ _____
Signature Date

EMERGENCY CONTACT INFORMATION

Please give an emergency contact. Put a check mark next to the phone number to call first.

Contact name _____ Relationshiip _____

Home (____) _____

Work (____) _____

Cell (____) _____

Primary Care Physician: Name _____ Phone (____) _____

Address _____

City _____ State _____ Zip _____

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088
http://www.chirowarren.com/
A non-partnership of independent practitioners

586 / 293 - 4440 • Fax 586 / 293 - 0840

Rev. 9/28/10

MISSED APPOINTMENTS POLICY

We ask for your assistance and cooperation in keeping your scheduled appointment date and time.

It is our policy that if a patient misses or cancels an appointment with less than 24 hours notice, that patient will be charged the regular office visit fee for that time. This policy is necessary to avoid the numerous schedule problems that last minute cancellations and missed appointments create!

If the need arises to cancel or change your appointment, we would appreciate 48 hours notice, when possible, but no less than 24, to avoid an unnecessary charge to you.

We thank you for your cooperation and look forward to being a vital part of your health recovery and maintenance.

I have read and understand the above policy:

_____ _____

Patient Signature Date

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HIPAA: CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I acknowledge that the Chiropractic Associates of Michigan Notice of Privacy Practices has been provided to me.

I understand my right to review the Chiropractic Associates of Michigan (CAM) Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of CAM. This Notice of Privacy Practices also describes my rights and CAM duties with respect to my protected health information. The Notice of Privacy Practices for CAM can be provided, on request, at the front desk.

Chiropractic Associates of Michigan reserves the right to change the privacy practices described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be mailed, or by asking for a copy at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that CAM has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge receipt of a copy of this notice, and my understanding, and agreement, to the terms:

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

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