NEW PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

Social Security #: _____ Driver's License #: _____

Birth Date: _____ Age: _____ Sex: _____

Martial Status: _____ Number of Children: _____

Occupation: _____ Employer: _____ Work #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

The information I have presented above is true, and to the best of my knowledge.

Patient Signature: _____ **DATE: _____**

Rupeshbhai A. Patel, DC

Affordable Healthcare bIlling & Management Services, inc.

DBA: CCTHECHIRO

Mailing Address: PO BOX 1499, BAKERSFIELD, CA 93302

Phone #: 818-543-1544

Fax #: 818-543-1548

INFORMED CONSENT: For All Chiropractic Exam & Treatments: A Standard of Care.

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. As there are risks to any medical treatment, chiropractic care also has risks ranging from minor to material. Please know that there are alternatives to chiropractic treatment, including but not limited to medications, injections, or surgery, each with its minor to material risks.

This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you: it is simply an effort to make you better informed, so you may give or refuse your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including examination and various modes of physiotherapy.

I have the opportunity to discuss with Dr Rupeshbhai A. Patel, D.C., my diagnosis, the nature and purpose of my chiropractic treatment, alternatives to my chiropractic treatment, and risks and benefits of alternative treatment, including no treatment at all.

The clinic generally uses gentle manipulation techniques; however, it is the patient's responsibility to inform the doctor of this clinic if the patient thinks or feels there are any reasons why the clinic's care may not, now or later, be appropriate or beneficial in any way. Some of the complications of manipulation and therapy include, but are not limited to, fractures, injuries, burns, and, in the case of cervical manipulations, there is a one in 5 million chance of stroke, making this an extremely rare rate of incidence.

ESSENTIAL: Please note that without signing this form, we may not initiate any care. Our clinic has the right to refuse care to anyone. Patients have the right to ask as many questions to the doctor as necessary.

I hereby request and consent to the performance of all examinations and treatments, including manipulative therapy and physiotherapeutic modalities by Dr Rupeshbhai A. Patel, D.C.

I HAVE READ [ ] or HAD IT READ TO ME [ ] or was translated to me the above explanations. I have discussed it with the doctor and have had all my questions answered to my satisfaction. I know that I am advised by the clinic to consult my primary medical physician regarding chiropractic and alternative care. Having been informed of the benefits and risks of the clinic's treatments, I hereby consent to all examinations and treatments necessary for any physical complaints now and in the future. The doctor will gladly explain and rediscuss any such questions and concerns.

Patient Name: _____ Today's Date: _____

Patient Signature: _____

Parent's or Guardian Signature: (If a minor): _____

Doctor's Signature: _____ Date: _____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, we must require you to read & this consent form stating that you understand and agree with how your records will be used. Suppose you would like to have a more detailed account of our policies and procedures concerning the privacy of your patients' health information. In that case, we encourage you to read the HIPAA notice that is available to you at the front desk before signing.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company or companies provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company requires for payment.
2. The patient has the right to examine and obtain a copy of his or 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 needs only to be obtained once for all subsequent care given to the patient in this office.
4. The patient may provide a written request to provoke consent at any time during care. This would not affect 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 have 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 that are known by this office to ensure 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 position has the right to refuse to give care.

I HAVE READ AND UNDERSTOOD HOW MY PATIENT HEALTH INFORMATION WILL BE USED, AND I AGREE TO THESE POLICIES AND PROCEDURES.

Patient Print Name: _____

Patient Signature: _____

Today's Date: _____

Rupeshbhai A. Patel, DC

Affordable Healthcare billing & Management Services, inc.

DBA: CCTHECHIRO

Mailing Address: PO BOX 1499, BAKERSFIELD, CA 93302

Phone #: 818-543-1544

Fax #: 818-543-1548

FINANCIAL COMMITMENT AND PERSONAL LIEN

- No other arrangements have been made except for payment in full charges.
- If third-party payment is not received, then I agree that it is my responsibility to pay for the office charges in full.
- If payment is not made on time, then there will be a monthly interest charge added to the total amount due.
- If my account remains unpaid, 10% interest as well as collection charges, attorney, and court costs will be added to my balance.
- I, the undersigned, do hereby agree to pay Dr Patel's billing service (Affordable Healthcare Billing & Management Services, Inc.) any remaining balance on my account within (3) days of receiving on-hold funds. Once funds to cover treatment fees have been received, I agree to pay for services rendered on the same day treatment was received.
- I hereby authorize Dr Patel to release any and all records pertaining to my care.
- I hereby authorize any healthcare provider or facility to release my medical records and reports to Dr Patel.
- I hereby assign benefits to Dr Patel's billing service (Affordable Healthcare Billing & Management Services, Inc.), to be paid directly and in full for the services provided in reference to my illness or injuries.
- I also direct my insurance company to pay Dr Patel's billing service (Affordable Healthcare Billing & Management Services, Inc.) directly and authorized Dr Patel's billing service (Affordable Healthcare Billing & Management Services, Inc.) to sign all checks made to my name, in reference to the provided services. If payment for services is inadvertently mailed to my attorney or me, I agree that I will personally deliver the payment to Dr Patel's billing service (Affordable Healthcare Billing & Management Services, Inc.).

Cancellation/No-Show Policy:

- Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctor's day that could have been filled by another patient. As such, we require a 24-hour notice for any cancellations or changes to your appointment. Patients who provide less than a 24-hour notice or miss their appointment will be charged a cancellation fee to the card on file.

I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE

Patient Print Name: _____

Patient Signature: _____

Today's Date: _____

Date of Injury: _____

Rupeshbhai A. Patel, DC

Affordable Healthcare bIlling & Management Services, inc.

DBA: CCTHECHIRO

Mailing Address: PO BOX 1499, BAKERSFIELD, CA 93302

Phone #: 818-543-1544

Fax #: 818-543-1548

Affordable Healthcare Billing & Management Services, Inc. DBA: CCtheChiro

PHYSICIAN – PATIENT ARBITRATION AGREEMENT

Article 1: Binding Agreement to Arbitrate: it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to binding arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it or giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of arbitration.

Article 2: All Claims must be Arbitrated: It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the position, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence that gave rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress, or punitive damages. Filing of any action in any court by the position to collect a fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedure and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within 30 days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within 30 days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such parties pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator. The party's consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agreed that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including but not limited to Code Civil Procedure Sections 340.5 and 677.7 and Civil Code Sections 333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 128.05. However, dispositions may be taken without prior approval of a neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrator shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the position within 15 days of signature. It is the intent of this agreement to apply to all medical services rendered anytime for any condition.

Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should sign below.

Independent Counsel: Each party has had the opportunity to be separately represented by independent counsel prior to the execution of this agreement and in the absence of having obtained independent counsel, has waived that opportunity prior to the execution hereof. If any provisions of this arbitration agreement are held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUES OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP OUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Print Name: _____

Patient Signature: _____

If Representative, Print Name and Relationship to Patient: _____

Date: _____

Physician Signature: _____**Date:** _____

DOCTOR'S LIEN & RELEASE OF MEDICAL DOCUMENTS

Rupeshbhai A. Patel, DC

Affordable Healthcare Billing & Management Services, Inc.

DBA: CCTHECHIRO

Mailing Address: P.O. BOX 1499 Bakersfield, CA 93302

Phone #: 818-543-1544

Fax #: 818-543-1548

TO ATTORNEY ON THE CASE OF (Patient Name): _____ Date of Injury: _____

This is a contract and a legally binding document that binds the attorney and patient to ensure that the doctor's billing service (Affordable Healthcare Billing & Management Services, Inc.) is paid for the patient's services once the above-referenced case is settled or a verdict is received. **PLEASE SIGN AND FAX BACK TO 818-543-1548**

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his / her examination, diagnosis, treatment, prognosis, et cetera, of myself in regards to the accident dated

(Date of Injury): _____

I hereby authorize and direct you, as my attorney for the personal injury case, to pay directly to said doctor's billing service (Affordable Healthcare Billing & Management Services, Inc.) such sums as may be due and owing him/her for chiropractic care and services rendered me both by reason of this accident and by reason of any other bills that are due his / her office and to withhold such sums from any settlement, or verdict as may be necessary to adequately protect such lean. This is a third-party lien given by the undersigned client to the benefit of the treating chiropractor for the above-mentioned case. Your client instructs you not to revise this agreement and sign it no later than 7 days from the date you received this document.

I understand that I am directly responsible for the said medical bills and for all medical bills incurred for services, regardless of the outcome of the case. I understand that if the doctor is not successful in contacting the attorney or if the attorney refuses to cooperate or pay the said doctor for the services rendered to me, this lien will then be void, and I am personally responsible for the outstanding medical bills.

Patient Print Name: _____

Patient Signature: _____

Today's Date: _____

The undersigned being the attorney for the injured party hereby agrees to observe all the terms of this agreement between the doctor and the client, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect the said doctors lean, as well as pay the doctor to satisfy this lien within seven days of said settlement, judgment or verdict. ALL PAYMENTS ARE TO BE MADE AND MAILED TO AFFORDABLE HEALTHCARE BILLING AND MANAGEMENT SERVICES, INC. If a dispute arises from this agreement and if the doctor prevails, the attorney or patient, as ordered by the court, will be responsible for paying for actual attorney fees and costs.

A COPY OR A FAX COPY OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL

Attorney for Client: _____

Attorney Address: _____

Attorney Signature: _____

Date Signed: _____

Rupeshbhai A. Patel, DC
Physical Address: 1039 17th Street
Bakersfield, CA 93301
Ph: (818) 543-1544
Fax: (818) 543-1548

Affordable Healthcare Billing & Management Services, Inc
DBA: CCTHECHIRO
Mailing Address: P.O. BOX 1499
Bakersfield, CA 93302

ASSIGNMENT OF MED-PAY BENEFITS TO DR. PATEL'S BILLING SERVICE, BELOW.

POWER OF ATTORNEY TO DR. PATEL'S

BILLING SERVICE, BELOW.

ALL CHECKS TO BE MADE PAYABLE TO:

Affordable Healthcare Billing And Management Services, Inc.

P. O. BOX 1499, BAKERSFIELD, CA 93302.

POLICY/CLAIM#: _____

DATE OF FIRST VISIT: _____

You are hereby instructed and directed to pay Dr. Patel's billing service, Affordable Healthcare

Billing And Management Services, Inc., in full for all Med-Pay claims for the professional services rendered to me by his office since the date shown above.

I also direct you to pay Dr. Patel's billing service directly, and all claim checks must be made out to Affordable Healthcare Billing And Management Services, Inc., and mailed to P.O. Box 1499, Bakersfield, CA 93302. Thereby, I assign Dr. Patel's billing service, Affordable Healthcare Billing And Management Services, Inc. power of attorney to cash all checks made to my name, to Dr. Patel's name, or to our names jointly. Affordable Healthcare Billing And Management Services, Inc. has full power of attorney to sign for any and all correspondence and checks made to me or in my name.

I have read and agreed to all the statements described above.

Dated and accepted: _____

Patient's Signature: _____

Insured's Name (Please Print): _____

Witness: _____

CONSENT TO TREAT A MINOR

Rupeshbhai A. Patel, DC
1039 17th Street
Bakersfield, CA 93301
Ph: (818) 543-1544
Fax: (818) 543-1548

I, hereby authorize Dr. Rupeshbhai A. Patel, DC, to examine and treat my son/daughter:

NAME: _____

PARENT/LEGAL GAURDIAN NAME (PRINT): _____

PARENT/LEGAL GAURDIAN NAME SIGNATURE: _____

DATE: _____

Rupeshbhai A. Patel, DC
Physical Address: 1039 17th Street
Bakersfield, CA 93301
Ph: (818) 543-1544
Fax: (818) 543-1548

Affordable Healthcare Billing & Management Services, Inc
DBA: CCTHECHIRO
Mailing Address: P.O. BOX 1499
Bakersfield, CA 93302

Request for Medical Records

For Med-Legal and Continuity of Care Use

Patient Information

Full Name:
Date of Birth:
Address:
Phone:
Email:

Records Requested From

Facility / Provider Name:
Address:
Phone:
Fax / Email (for record transmission):

Records Requested By (Requesting Provider)

Clinic Name: CCtheChiro
Requesting Provider: Dr. Rupeshbhai A. Patel
Address: 1039 17th St. Bakersfield, CA 93301
Phone: 818-543-1544

Purpose of Request

□ Continuity of Care □ Med-Legal Evaluation □ Insurance / Billing □ Independent Medical Review
□ Other: _____

Description of Records Requested

Please release complete medical records, including but not limited to:- Office and treatment notes- Imaging reports (X-ray, MRI, CT)- Diagnostic test results- Consultation reports- Medication and allergy history- Operative and discharge summaries- Any records related to injury dated: _____

If only a specific range or type of records is needed:

□ Records from _____/_____/_____ to _____/_____/_____

□ Specific records: _____

Authorization to Release Information

I hereby authorize the above-named facility/provider to release my protected health information (PHI) as specified in this request to **CCTHECHIRO** or its authorized representatives. This authorization includes the release of any information protected under federal or state confidentiality laws (including, where applicable, information relating to HIV/AIDS, mental health, or substance use), unless I specifically exclude such information below:

□ Exclude mental health records □ Exclude HIV/AIDS testing information □ Exclude drug/alcohol treatment records

Delivery Method

[X] Fax to: **818-543-1548** □ Secure email to: _____ □ Mail to: _____ □ CD/USB / Electronic Portal (preferred if available)

Timeliness of Release

Per HIPAA 45 CFR §164.524(b)(2) and California Health & Safety Code §123110, records must be released within 15 days of receipt of this valid request. If additional time is required, please provide written notice stating the reason for the delay and the expected release date.

Patient Authorization

I understand that:- This authorization is valid for one year from the date signed unless revoked in writing.- I may revoke this authorization at any time in writing to the provider listed above.- Once released, the information may be subject to redisclosure by the recipient and may no longer be protected under federal privacy regulations.- A photocopy or electronic copy of this authorization shall be considered as valid as the original.

Patient / Legal Representative Signature: _____

Date: _____ Relationship (if not patient): _____

For Office Use Only

Date Request Sent: _____ Method of Transmission: Fax / Mail / Portal / Email Follow-Up Date (15 days): _____ Records Received: □ Yes □ No Date Received: _____