Chiropractic Acupuncture Health Center
Dr. Cherie Johnson
205-408-5600
chiropractichealthal@gmail.com

PATIENT NAME: FIRST_____ LAST: _____
ADDRESS:_____CITY_____ZIP CODE:_____
EMAIL:_____BIRTHDATE: _____/_____/_____ PHONE: _____
Insureds Date of Birth: _____/_____/_____

CONSENT FOR CHIROPRACTIC AND ACUPUNCTURE SERVICES As an established patient of Chiropractic Acupuncture Health Center (CAHC), I give consent to the doctor of CAHC to administer whatever therapeutic procedure of device as deemed necessary to treat my condition. I acknowledge that no guarantee of assurance of the results of treatment can be given to me by the above attending chiropractor, associate or assistant. And this consent will serves as blanket consent as long as I am an active patient of CAHC.
Signature: _____ Date: _____/_____/_____

BLANKET AUTHORIZATION AND ASSIGNMENT FOR ESTABLISHED PATIENTS If insurance assignment is accepted, as an active patient with CAHC, I authorize release of all information regarding my condition to any Insurance Co., Attorney, or adjuster in order to process any claims for reimbursement and release you of any consequences thereof. I also assign to you the cause of action that exists in my favor, so that you may act in my behalf to resolve any insurance claim; and I direct any insurance plan or benefit obligated to reimburse me for covered services to make payment directly to the providers at CAHC. I understand and agree that health/accident/workers comp insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that CAHC will prepare any necessary reports and forms to assist me in making collection for the ins. company and that any amount authorized to be paid directly to CAHC will be credited to my account on receipt. However, I clearly understand that if I suspend or terminate my care, treatment, and fee for professional services rendered me will be immediately due and payable. If there are any issues with my appointment time, I will cancel or reschedule 24-2 hours *prior. For any missed appointment without notification, I will be charged a $25 missed appointment fee. Signature: _____ Date: _____/_____/_____ Insurance may be late to send payment and because your insurance may not cover 100% of billable charges, a credit card MUST be on file with our office. We will automatically charge the card through a Virtual terminal by MOTO Credit card due to: > Deductible and copay not paid when services rendered>>Patient terminates treatment plan>>Patient does not abide by payment plan agreement>>There hasn't been any payment made to an account within days>>Insurance does not cover all charges>>Supplements, missed appointments, other verbal fees. I understand that my credit card I have on file, will be run for services/ products by terminal or virtual MOTO at CAHC, and I give consent to CAHC to run my credit card by terminal and Virtual MOTO. Signature: _____ Date: _____/_____/_____ I,_____, herby authorize Chiropractic Acupuncture Health Center to initiate debit/credit card charges and corrections to previous debit/credit card charges to my account, with the financial institution connected to my credit card for payment services/products rendered to me. If at any time, a card on file is stolen or lost, I will update this with CAHC at the time of the visit. I understand this office will run my credit card Virtually by MOTO with each service that I owe, unless otherwise noted to the clinic. These signatures will continue to apply to each and all terminal transactions through CAHC for two years. This authorization will remain in effect for two years. CREDIT CARD(S) on file: 1) (last four digits) ___ ___ ___ ___ Visa® MasterCard® Discover® EXP. Date _____/_____ 2) (last four digits) ___ ___ ___ ___ Visa® MasterCard® Discover® EXP. Date _____/_____ 3) (last four digits) ___ ___ ___ ___ Visa® MasterCard® Discover® EXP. Date _____/_____ Card Holder Name: _____ Signature:_____ Date: _____/_____/_____ I agree, that any credit or debit card charge made at or for CAHC clinic cannot be sent to any credit card company or bank for a dispute or fraudulent charges. I agree, that if any type of dispute or fraud charge is filed against CAHC, I will be charged a $50.00 for each visit disputed. From the date of said $50.00 fees, I will have 60 days to pay my balance in full of my account or it will be sent to collections. I agree CAHC my contact me by telephone, wireless telephone numbers, text messages, emails. Messages may include prerecorded/artifical voicemessages and automatic dialing devices. I have read this diclsure and agree that CAHC may contact me as described: Responsible party Signature:_____ Date: _____/_____/_____*

I give consent to the Doctor of CAHC to administer whatever treatment, examination, or therapeutic procedure or device as deemed necessary to treat my condition. I also give consent to the Doctor of CAHC to provide any form of nutritional recommendation, advice, dietary recommendation, vitamin and supplement recommendation. Signature:_____