EMIHAN CHIROPRACTIC CLINIC, INC
Dr. Sang Jun Baek D.C., M.S.

PATIENT REGISTRATION FORM

Date: ____(MM)/____(DD)/_____(YEAR)

It is important that you answer all of the questions that apply to you to the best of your knowledge. If you have any questions or need assistance, please let the Receptionist know. Thank you.

- Last Name, First Name: _____
- Date of Birth: _____ Sex: ☐ Male / ☐ Female
- Street Address: _____CITY_____ZIP_____
- Phone Number: ( )_____-_____ E-mail : _____
- Referred by: _____

- Is this visit due to an accident? ☐ Yes / ☐ No (If, No, skip to the next block.)
- If, yes, Date of Accident _____
- Type of Accident?

☐ Auto / ☐ Work related) / ☐ Home / ☐ Other _____

- If Accident, please describe in your own words how it happened:

_____
_____
_____
_____

- Have you been in an auto accident? If, Yes, when?

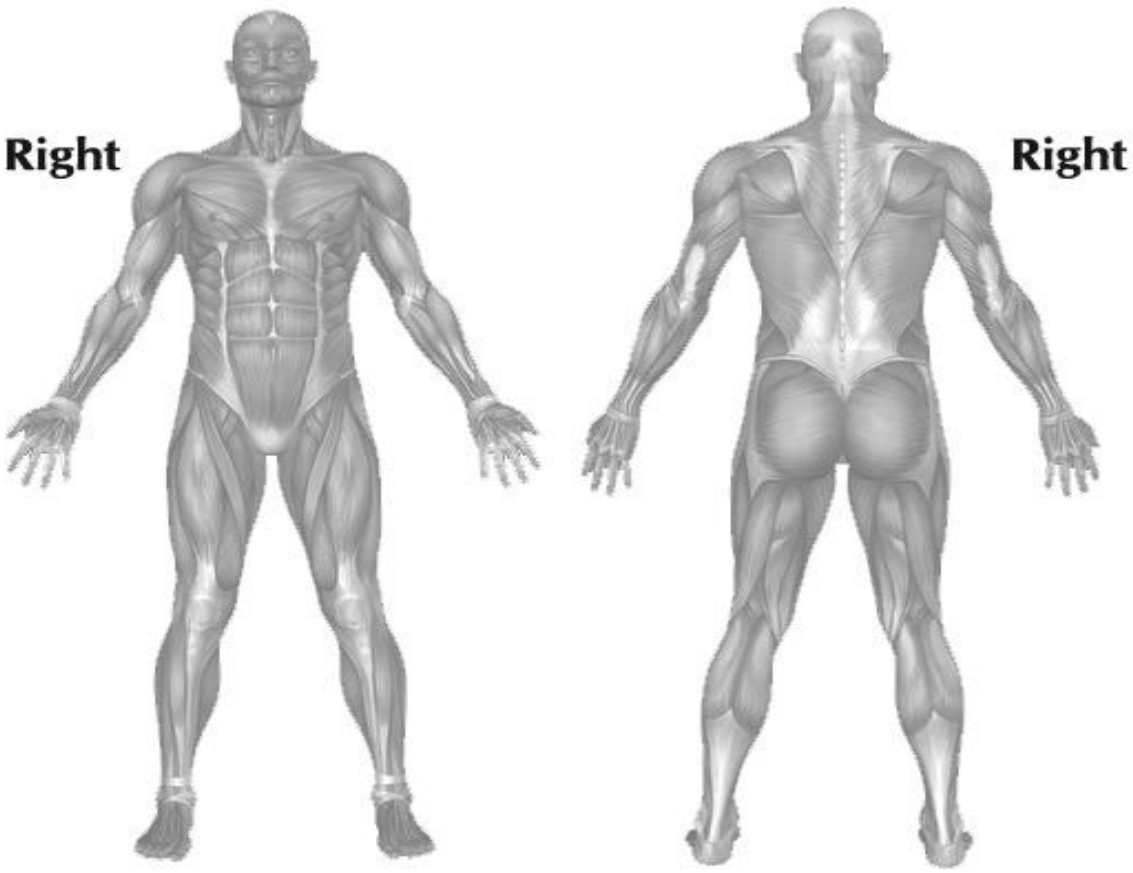
_____

- Have you had any other personal injury or accident? If Yes, when? _____
- If, you have, briefly describe

_____
_____

1507 E. SANDY LAKE RD #140
COPPELL, TX 75019

✍ Mark the areas of the body where you feel the described sensations. Use the appropriate symbol. Include ALL affected areas.



✍Please describe your **Major Complaint** in your own words. (Where, How, In what form and In what situation)

_____
_____
_____
_____
_____
_____
_____

✍ Have you been knocked unconscious? ☐ Yes / ☐ No
If, Yes, explain why _____
✍Are you using a cane or crutch, etc? ☐ Yes / ☐ No
If, Yes, explain why _____
✍ Are you wearing Heel lifts or similar?
If, Yes, explain why _____
✍Have you had a fractured bone? ☐ Yes / ☐ No
If, Yes, explain why _____
✍ Have you been hospitalized for other than surgery? ☐ Yes / ☐ No
If, Yes, explain why _____
✍ Have you been treated for a spine disorder? ☐ Yes / ☐ No
If, Yes, explain why _____

✍ To your knowledge, have you any metal in your body such as surgical wire, implants, metal fragments that have not been removed? If, Yes, explain
_____
_____

✍ Have you ever had Chiropractic before? If, Yes, Name of Doctor , Treated for, Results)
_____
_____
_____
Is there any possibility that you are pregnant at this time? ☐ Yes / ☐ No

✍Write the person's name responsible for payment of the account.

_____
_____
_____
_____

* If, you have the Insurance, please give card to Receptionist.

I certify that the above information is correct to the best of my knowledge.

Patient's Signature:_____

Note: Our regular case history and consulting is $50.00. In addition, patients shall pay additional $50.00 for examination if they agree to perform examination with doctor's advice.

General Consent for Care and Treatment Consent

1507 E. SANDY LAKE RD #140
COPPELL, TX 75019

EMIHAN CHIROPRACTIC CLINIC, INC
Dr. Sang Jun Baek D.C., M.S.

(PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF CARE AND TREATMENT)

TO CARRY OUT TREATMENT AND HEALTH CARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows;

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended chiropractic, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue service.

You have the right to discuss the treatment plan with Dr. Baek about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request Dr. Baek and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

_____ _____
Print Name Signature

_____ _____
Signature of Legal Representative* Relationship

Date Signed __ /__ /____ Witness:_____

*Attorney-In-Fact, Guardian, Parent if a minor

1507 E. SANDY LAKE RD #140
COPPELL, TX 75019

EMIHAN CHIROPRACTIC CLINIC, INC
Dr. Sang Jun Baek D.C., M.S.

Protected Health Information

(PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION)

TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows;

The Practice's Privacy Notice has been provided in the following.

1. 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, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent)
2. In accordance with the applicable Health Insurance Portability and Accountability Act of 1996, the Practice reserves the right to change its privacy practices that are described in its Privacy Notice to be current and in the best interest of a patient's privacy rights.
3. 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.
4. 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.
5. 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 has already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

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

_____ _____
Print Name Signature

_____ _____
Signature of Legal Representative* Relationship

Date Signed ___ /___ /____ Witness:_____

*Attorney-In-Fact, Guardian, Parent if a minor

1507 E. SANDY LAKE RD #140
COPPELL, TX 75019

Semihan Chiropractic Clinic, INC

Late, Cancellation, and No-Show Policy

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way. However, if you are more than ***15 minutes late*** you will have to reschedule your appointment.

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. The charge for not canceling within a 24 hour notice is **$50.00**, which will be charged to your account and is not payable by any insurance company.

Patients who "No-Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

Informed consent /Agreement:

□ I have been informed of and understand the Clinic's late policy.

□ I have been informed of and understand the Semihan Chiropractic Clinic INC's No Show/ Late Cancellation Policy. I understand that a no-show or late cancellation will result in a **$50.00** Charge that is not covered by any insurance. I understand that three consecutive no show or late Cancellations may result in dismissal from the Clinic.

Signature of Patient / Guardian: _____ Date:_____

INSURANCE DISCLAIMER

Insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, you the patient are responsible for the non-covered services.

Payment is due at the time of service, unless payment arrangements have been made with the Semihan Chiropractic Clinic, Inc.

Unpaid balances after 90 days are to be turned over to collections and interest will be added on to the account for each month it is overdue. If the account goes into the legal phase of collections your bill is accrued to double in cost due to legal fees. This will only go into effect if you have not made a payment arrangement with the Semihan Chiropractic Clinic, Inc.

I understand that if my insurance company does not cover the services rendered, I am personally and fully responsible for the payment in full to the Semihan Chiropractic Clinic, Inc.

_____ _____

Print Patient Name Signature

Date Signed ____ /____ /_____

* Regardless of what your insurance states, if we are not in your network, you as a patient are still responsible for the charges.

* SOME X-RAYS AND THE G-5 MASSAGE, MAY NOT BE COVERED.