GALLA CHIROPRACTIC GROUP
REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Occupation:_____ Employer Name:_____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to **Galla Chiropractic Group** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Hip right/left	Shoulder right/left	Knee right/left
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy:** **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Patient Name: _____ **Date:** _____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:
Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Patient Name: _____ **Date:** _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :_____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro :_____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :_____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Patient Name: _____ **Date:** _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ United HealthCare	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Anthem/BCBS	☐ Worker's Compensation	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone: _____
Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:
Name & Address:

_____

_____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:

_____

_____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

_____

Patient Name: _____ **Date:** _____

GALLA CHIROPRACTIC GROUP

MOTOR VEHICLE COLLISION QUESTIONNAIRE
Please answer all questions completely:

1: Your name and address:

_____

_____

2: Phone Number: _____

3: Please describe the collision in your own words:

_____

_____

4: Where did the collision occur? City/Town: _____ State: _____

5: Date of collision: _____ Time: _____ AM PM

6: Were you the: ☐driver ☐passenger ☐pedestrian

7: If passenger, were you in the ☐front seat ☐right rear seat ☐left rear seat

8: What type of vehicle were you in? _____

9: What type was the other vehicle? _____

10: Did your vehicle strike the other vehicle? ☐yes ☐no

11: Was your car struck by the other vehicle? ☐yes ☐no

12: What direction was your vehicle going? _____

13: What direction was the other vehicle going? _____

14: Was the impact from: ☐the front ☐the rear ☐the left side ☐the right side

15: What was the approximate speed at the time of the impact?

16: Your vehicle _____ mph Other vehicle _____ mph

17: What was the weather at the time of the collision? ☐dry ☐wet ☐icy

18: Was your vehicle in: ☐park ☐neutral ☐in gear ☐moving ☐stopped

19: Were your brakes being applied? ☐yes ☐no

20: Was your vehicle shoved: ☐forward ☐backward ☐sideways

21: Were you shoved: ☐forward ☐whipped backward

22: Did your seat have a head restraint (headrest?) ☐yes ☐no

Patient Name: _____ Date: _____

23: If yes, what was the position □low □mid-position □high

24: Did your head ride over the headrest? □yes □no

25: Did your hat/glasses end up in the back seat or rear window? □yes □no

26: Did any other part of your body hit the interior of the vehicle? □yes □no

27: If yes, please specify: □seatbelt restraints □steering wheel □dashboard □windshield □side door □side window □other _____

28: Which part of your body? □chest □head □chin □face □ R L knee □ R L shoulder □ R L hand □other _____

29: Were you holding on to the steering wheel? □yes □no

30: Did you brace your arms against the dash? □yes □no

31: Did you brace your legs against the floorboard? □yes □no

32: Was your ankle turned? □yes □no

33: Did the vehicle go into a spin or roll as a result of the impact? □yes □no

If yes, explain: _____

34: How much damage was there to the outside of the vehicle? □none □some □a lot

35: How much damage was there to the inside of the vehicle? □none □some □a lot

36: At the point of impact, where did you experience pain? Be specific:

_____

37: Immediately after the accident were you: □conscious □dazed □unconscious

38: If you lost consciousness, how long? _____

39: Were you wearing a seat belt? □yes □no

40: Did the belt have a shoulder harness? □yes □no

If yes, did it contribute to the pain you are experiencing? □yes □no

41: At the time of impact were you: □looking straight ahead □looking to the right □looking to the left □looking down □looking up

42: Did the seat break as a result of the impact? □yes □no

43: Were you braced for the impact? □yes □no

44: Were you surprised by the impact? □yes □no

45: Did you go to the hospital? □yes □no

46: If yes, when? □right after the accident □next day □other _____

47: If yes, how did you get there? □ambulance □other: _____

Patient Name: _____ Date: _____

48: If by ambulance, did the ambulance attendants place you in a: □neck brace □back brace □other _____

49: Any medication or medical supplies given? _____

50: Did you have x-rays taken at the hospital? □yes □no

51: If you went to the hospital, please answer the following:

Name of hospital _____

Treatment Received _____

52: Have you had any similar problems before? □yes □no

If yes, explain: _____

53: Are you diabetic? □yes □no

54: Do you have high blood pressure? □yes □no

55: Do you have low blood pressure? □yes □no

56: Do you have arthritis or degenerative joint disease? □yes □no

57: What type of work do you do? _____

58: What are your job requirements? _____

59: Have you lost any days of work from this injury? □yes □no

If yes, give dates: _____

Patient Name: _____ Date: _____

_____ Doctor Reviewed with Patient

Doctor Signature: _____ Date:_____

Galla Chiropractic Group

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and /or temporary increase in symptoms, lack of improvement of symptoms, burns and or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, stokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic are from this office.

Patient Name:_____ Signature:_____ Date:_____

Parent or Guardian:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____

Eric Galla, D.C.
9330 W. Flamingo Rd.
Suite 112A
Las Vegas, NV 89147

Phone: 702-932-6100
Fax: 702-932-6102
gallachiro@gmail.com
www.serenity-lv.com

Galla Chiropractic Group

Consent for Purpose of Treatment, Payment, and Healthcare Operations

I, _____(Name of Individual) consent to Galla Chiropractic Group's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information , including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment , or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describe my rights and the practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative: _____

Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

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OFFICE POLICY AND RULES AGREEMENT

1. I agree to silence my cell phone while in the office to prevent disturbing others during treatment hours. If I need to use my cell phone, I will go outside to do so.
2. I agree to keep the office updated with my current contact and insurance information. If I am working with an attorney, I will update the office immediately with new information.
3. I agree to keep my appointments and follow the schedule set forth by the doctor/and or massage therapist. If I have to miss an appointment, I will call at least 24 hours in advance during office hours to cancel my appointment. Failure to do so will result in a service charge that will be billed to me directly and is not payable by insurance, lien, workers compensation, etc. Service charges are due and payable at time of next appointment or within one week (whichever comes first).
4. I agree to follow all recommendations made by the doctor, including the proper use of my spinal supports, doing my exercises as prescribed, etc.
5. I agree to make a personal financial agreement and promptly fill out all necessary medical, legal and insurance forms to aid in the timely payment for my care.
6. I understand that if my insurance company has not paid my claim within sixty (60) days, a copy of that unpaid claim will be given to me and I will be responsible to follow-up on the statues of payment.
7. I further acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services Galla Chiropractic Group may place my account with a collection agency, I agree to pay reasonable collection fees, attorney fees and court cost incurred in collection of my overdue account.

Patient:_____ Signature:_____ Date:_____

Parent or Guardian:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____

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Galla Chiropractic Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Galla Chiropractic Group, which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

Date: _____

Patient Printed Name: _____

Patient Signature: _____

Witness Signature: _____

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GALLA CHIROPRACTIC GROUP

MANDATED RELEASE OF MEDICAL RECORDS

I understand that information regarding myself and family members will be kept confidential, within the confines of the treatments teams, unless express written permission is given to release information. However, exceptions to maintain confidentiality are **1. Incidents of mandating reporting; 2. When a court order is issued for records; 3. In the event that an individual is dangerous to self or others, at which time the minimal amount of information necessary will be shared to ensure the safety of the individual and others to provide for community of care.**

Finally, I understand that I may withdraw this consent for services at any time.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

I, _____, give Dr. Eric Galla and Galla Chiropractic Group staff authorization to disclose my protected health information to the following family, friends, and/or caregivers:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Patient Name:_____ Signature:_____ Date:_____

GALLA CHIROPRACTIC GROUP

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth: _____

Address: _____ Daytime Phone: _____

City/St/Zip: _____ Evening Phone: _____

I hereby authorize Galla Chiropractic Group to (choose one or both as appropriate):

☐ **use or disclosure my protected health information as indicated below *TO*:**

☐ **obtain my protected health information *FROM*:**

Name: _____

Address: _____Phone: _____

City/St/Zip _____Fax: _____

Information to be released for time period of to : _____ to _____:

☐ History and physical exam ☐ Immunizations

☐ Lab report ☐ X-ray report

☐ Consultation report/notes ☐ Prescription Information

☐ Notes and test results related to: ☐ Other/Comments: _____

I understand that this health information may include sensitive information. By signing this form I am specifically authorize the release of information relating to:

☐ Substance Abuse Treatment information ☐ HIV related information, including AIDS related testing

☐ Mental Health Information

Signature: _____ Date: _____

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Preferred Format: ☐ CD ☐ Paper

Purpose of Disclosure: ☐Treatment ☐Workers Compensation ☐Legal ☐School ☐Other:_____

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. Send revocation to: Galla Chiropractic Group, 9330 W. Flamingo Rd. 112A, Las Vegas, NV 89147
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient: _____ **Date**: _____

Parent/Legal Guardian/Authorized Person: _____

Relationship to Patient: _____

Galla Chiropractic Group

DOCTOR'S LIEN

To: Attorney/Insurance Carrier

_____

Address _____

City/St/Zip _____

Phone: _____

Fax: _____

Re: Patient Records and Doctor's lien for:

_____

_____

Date of Injury: _____

I do hereby authorize ***Eric Galla, D.C. of Galla Chiropractic Group*** to furnish you, my attorney or insurance company, with a full report of his examination, treatment, prognosis, etc... of myself in regards to the accident in which I was recently involved.

I hereby authorized and direct you, my attorney or insurance company, **to pay directly to said doctor such sums as may be due and owing her for medical services rendered to me** both by reason of this accident and/or by reason of any other bills that are due to his office and to **withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid** to you, my attorney or insurance company, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. And I hereby direct that **any and all sums to be paid pursuant to this lien will take priority to any and all payments which I may receive** as a result of the subject case and direct my attorney or insurance company to render payment to ***Eric Galla, D.C.*** prior to payment to myself.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for said doctor's protection and in consideration of his awaiting payment. And I further understand that **such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee**. I also direct the appropriate insurance carrier to make available a separate check payable to ***Eric Galla, D.C.*** or any authorized party, make such a request.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s), in conjunction with the appropriate insurance carrier.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient Signature: _____ **Date:** _____

The undersigned being either attorney of record or an authorized representative for insurance carrier on the record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. This lien in your possession acknowledges your agreement and fulfillment of said lien (with or without signature) unless refusal in writing via registered mail is received within 7 days. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney and /or Authorized Representative's Signature: _____

Description of Representative's Authority: _____ **Date:** _____

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Galla Chiropractic Group

IRREVOCABLE ASSIGNMENT OF BENEFITS

Patient Name: _____ SSN: _____

Claim # _____ DOI: _____

Insured's Name _____ Relation to insured _____

I hereby instruct and direct the _____ Insurance company to pay the benefits of my policy by check made out to and mailed directly to:

ERIC A. GALLA, DC

GALLA CHIROPRACTIC GROUP

9330 W. Flamingo Rd. #112A

Las Vegas, NV 89147

OR

If my policy prohibits direct payment to a doctor, then I hereby also instruct and direct you, my insurance company, to make the check out to me and mail it as follows:

C/O: **ERIC A. GALLA, DC**

9330 W. Flamingo Rd. #112A

Las Vegas, NV 89147

For the professional or chiropractic/medical benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AND IS IRREVOCABLE, EVEN BY MY ATTORNEY. DO NOT PAY THE BENEFITS OF THIS POLICY TO MY ATTORNEY AND DO NOT MAIL ANY BENEFIT CHECK TO MY ATTORNEY. Said payment will not exceed my indebtedness to Dr. Galla and I have agreed to pay, in a current manner, any balance of said professional services fees over and above this insurance payment. If my policy is an indemnity policy, I hereby direct you, my insurance company, to indemnify me against the harm that would occur should Dr. Galla have to balance bill me for professional fees that I contracted for an that you, my insurance company, fail to pay or fail to pay in full.

A Photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize Dr. Galla to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I further authorize Dr. Galla, to file a complaint on my behalf with the Nevada Insurance Commissioner.

Signature of Policyholder: _____ Date: _____

Signature of Claimant, if other than Policyholder: _____ Date: _____

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Galla Chiropractic Group

THIRD PARTY CLAIM AWARENESS

I have been made aware that my claim is a third party claim. My claim will not be paid until I have completed my treatments. The insurance company will be notified when my case is finalized. The insurance company will send me a check for the full amount of my claim. I understand that I am fully responsible for all incurred charges in this office and will pay Galla Chiropractic Group as soon as the insurance company settles my case and sends me the check.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date:_____

I grant permission to my attorney and/or insurance company to divulge all information regarding my case and insurance coverage to any authorized agent of Galla Chiropractic Group. This includes, but is not limited to, third party information, settlement, disbursement, and policy limits.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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