

Informed Consent for Examination and/or Treatment

I (we) hereby consent to the performance of examination and/or treatment on me by the licensed medical doctors, doctors of chiropractic and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor or therapist uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I will have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different therapy procedures and treatments (medical care/manipulation/adjustments) prior to any care being rendered.

I further understand that there are certain degrees of risk associated with medical care, chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period _____.

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed
By patient

Witness

OFFICE FINANCIAL POLICY

- 1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Balances must be kept current to continue care.
- 2. **If You Have Insurance that we accept:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be discontinued. Our payment plans make care an affordable part of your family budget.

You are considered a “self pay patient” until you bring in your completed insurance forms, and we verify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

- 3. **Cancellation Policy:** Our office prided ourselves on our ability to see patients on time and within 24 hours of a requested appointment. In order for us to maintain this level of service we have the following cancellation policy. We require **24 prior hours notice for all cancellations**. There will be a **fee** for all cancellations with less than 24 hours notice.

1 st Cancellation	Fee waived
2 nd Cancellation	\$50 fee
3 rd Cancellation	100% of the visit fee

Please understand that many times we have patients in pain waiting for treatment at certain times during the day. In order to preserve our ability to see these emergency patients without a protracted wait, we will need to ask all patients to give us notice if they need to change their appointment schedule in advance. Thank you for your understanding.

Patient's Printed Name: _____

Patient Signature _____ Date: _____

Finance Counselor: _____ Date: _____

PRACTICES NOTICES

Keeping you informed and protecting the privacy of your personal health information is important to us. Please read the following information.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you.

Our office location is the residence of several professional healthcare practices, some of which are independent of one another. There are several specialties "M.D.s or Medical Doctors, D.C.s or Chiropractic Doctors, "P.T.s" or Physical Therapists and "N.P.s" or Nurse Practitioners. You may or may not see more than one type of healthcare professional during your care in this office and each will maintain independent records of your care, which is part of your healthcare information. Some of these practitioners may be covered by your health insurance while some may be considered "out of network providers" and not participate with your insurance plan, which may subject you to additional out of pocket costs. (To avoid "role confusion" or unexpected costs, if you have any questions or concerns about what type of care you are receiving, or what type of professional is rendering that care, or whether that care is covered by your insurance, please let us know immediately and our staff will be happy to discuss it with you prior to any care.).

Our office staff may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be displayed on our office website.

The effective date of this Notice of Information Practices is February 1, 2012.

Patient's Initials: _____