CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in the accordance with the appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defects, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____

Patient's Signature **DATE**

X-RAY QUESTIONAIRE: **FOR WOMAN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name:_____

☐ There is a possibility that I may be pregnant at this time

☐ Yes. I am definitely pregnant

☐ No. I am definitely not pregnant at this time

☐ I request that x-rays films not be taken because_____

_____

Date of last menstrual period:_____

_____

Patient's Signature **DATE**

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee all forms have been completed correctly and to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information provided.

Signature_____ Date _____/_____/_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

OFFICE FINANCIAL POLICY

Our financial policy is to extend you the courtesy of allowing you to assign your Insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under care.

IF YOU DO NOT HAVE INSURANCE: All payments are expected at the time of service or by the authorized payment plan. Your personal balance **may not** exceed **$100.00** at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a self pay patient until you bring your completed insurance information and we qualify 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.

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.

Financial Plan

☐ Self Pay ☐ Insurance ☐ Medicare

MEDICARE PATIENTS ONLY: Medicare **does** cover Chiropractic Care, but with limitations. Not covered are:

1) Initial Examinations 2) Re-exams 3) Therapy 4) Supplements 5) Supports 6) Or other services offered in this office

THE ONLY SERVICES COVERED BY MEDICARE IS THE MANIPULATION OF THE SPINE.

I have read and understand the above statement.

Signature_____(Medicare Patient) Date:_____/_____/_____

I have read and agree to the terms of Charlotte Chiropractic Clinics financial policy.

Patient Name (Please Print)_____

Signature_____ Date_____/_____/_____

For your convenience you may retain your credit card number with us

Card #_____ Expiration Date _____/_____/_____ CVC Code _____

Name as appears on card_____ Visa_____ MC_____ Discover_____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for **six(6)** years.

By checking the lines below I authorize being contacted for practice reminders by:

- ☐ Mail
- ☐ Email email address _____
- ☐ Telephone numbers (_____)_____
- ☐ By voice mail
- ☐ By text message
- ☐ By FaceBook address _____

By checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:

- ☐ Mail
- ☐ Email email address _____
- ☐ Telephone numbers (_____)_____
- ☐ By voice mail
- ☐ By text message
- ☐ By FaceBook address _____

By checking the box below I authorize the doctor to personally discuss with me products that may benefit my health or condition.

_____ _____

Patient Name (please print) Date

_____

Name of Parent, Guardian or Patient's legal representative

_____

Signature of Patient, Parent, Guardian or Patient's legal representative

List below the names and relationship of people to whom you authorize the Practice to release PHI (Protected Health Information).

_____(NAME) _____(RELATIONSHIP)

_____(NAME) _____(RELATIONSHIP)

_____(NAME) _____(RELATIONSHIP)