

Heppner Chiropractic

Consent and Office Policies 2012

Name of Patient: _____ Date: _____

Name of Parent / Guardian / Patient Representative (if applicable): _____

PLEASE READ & INITIAL THE FOLLOWING:

_____ **Notice of Privacy Practices / HIPAA:** I acknowledge that a copy of this office's Notice of Privacy Practices has been made available for me to read and keep, if desired. I give my permission for my private health information to be used and shared for the following reasons:

- **To provide treatment** within our office
- **To obtain payment** from your Insurance company
- Other reasons as described in detail within the **Notice of Privacy Practices**

_____ **Payment for Services:** I understand that, as a courtesy to its patients, this office will help me to verify my Insurance benefits, estimate my portion, and to bill my insurance provider for services rendered. I understand that co-pays and deductibles are **due at the time of service**, as well as the cost of any non-covered products or procedures. While my insurance may pay for a portion of my care, I understand that **payment for all services rendered is ultimately my responsibility.**

_____ **Notification of Changes:** I understand that it will be my responsibility to notify this office if any information about me changes. This includes contact information (address, phone), **Insurance policy information**, account status (new work injury or auto injury). If I fail to do so in a timely manner, I understand that it I may be compromising my services may be denied by my insurance. **We will no longer treat patients under Workers Comp. Insurance as of 1/1/2012.**

If there are any changes in my **health history** (new diagnoses from other doctors, undergoing surgeries, taking new medicines, etc.) it will be my responsibility to discuss this with the doctor directly so that I receive the best treatment possible.

_____ **Consent to Routine Clinical Services:** I give my consent to all services rendered by the doctor(s), Licensed Massage Therapist(s), and/or chiropractic assistant(s) of Heppner Chiropractic or any other licensed doctor(s) or therapist(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that no guarantees have been made to me as to the result or cures that may be obtained from examination or treatment. I intend this consent to cover the entire course of treatment for my present condition and any further conditions for which I seek treatment. If I have any questions or concerns regarding specific benefits, risks, or alternatives of my care, I will ask about them before treatment is rendered.

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_____ **Cancellation Fee:** We will be charging a fee for **missing or cancelling** all appointments (chiropractic appointments or massages) without a 24-hour notice, this includes being more than 10 minutes late. **The fee will be equal to half of the amount of the services to be rendered during the appointment** (Ex. Chiropractic office visit = \$50, cancellation fee = \$25). We reserve the right to refuse service to any patient who is late for their appointment. If you are late, it will be at the discretion of the treating physician if you will be able to keep your appointment. These fees are not paid by insurance companies.

_____ **NSF Fee:** There is a \$25.00 fee for returned checks.

I have read, understood, and agreed to all of the initialed policies above.

Patient Signature (or Guardian Signature, if applicable) **Date**

Optional:

_____ **Authorization to Release Medical Information:** I give authorization to the staff at Heppner Chiropractic to release any information related to my medical care to the following person or people or to discuss my medical information in the presence of the following people. This authorization is good for one year from the date signed below.

(Name) (Relationship)

(Name) (Relationship)

_____ **Photo & Testimonial Release:** I grant Heppner Chiropractic permission to use my photograph and/or testimony for the purposes of promoting Heppner Chiropractic through any type of media including, but not restricted to websites, print, blogs, social networking, etc. The permission is granted without restriction. I agree to hold harmless Heppner Chiropractic from any claim, lawsuit, or further liability concerning photographs or testimonials.