Heppner Chiropractic
925 Commercial St. SE Suite #260
P.O. Box 4653
Salem, OR 97302
(503) 391-9222

Consent and Office Policies 2018

Name of Patient: _____ Guardian (if applicable): _____

PLEASE READ & INITIAL THE FOLLOWING:

_____ **Payment for Services:** I understand that **payment for all services rendered is ultimately my responsibility**. I will pay my co-pay, co-insurance, deductible, as well as the cost of any non-covered products or procedures **at the time of service**. Medicare plans will NOT COVER the cost of exams or anything except spinal adjustments. Oregon Health Plan will not cover any of our services. If I choose to wait past **60 days** after the date of service to pay my portion I will be charged a **15% fee** each month. Past 90 days, I understand that my unpaid bill will be sent to **collections**. I understand that there is a $25.00 fee for returned checks.

_____ **New accounts:** I understand that if this office and my insurance company haven't verified my cost for services before today's visit, I'll pay $25 towards my balance until that information is available.

_____ **Cancellation Fees:** I will not miss my appointments. If I am more than 15 minutes late or if I don't show up for appointments or if I cancel without giving 24-hour notice, **I'll pay $25 every time,** *regardless of the reason.* I understand that if my treatment is covered under an auto claim that **any late fees I accumulate will not be covered by my claim and are my personal responsibility.**

_____ **Notification of Changes**: I understand that it will be my responsibility to notify this office if any information about me changes including contact information, **Insurance information**, account status (new work injury or auto injury). If I fail to do so in a timely manner, I understand that my services may be denied by my insurance.

_____ **Consent to Routine Clinical Services:** I give my consent to services rendered by the providers who are now or will in the future treat me while employed by or associated with Heppner Chiropractic. I understand that no guarantees have been made to me as to the result or cures that may be obtained from examination or treatment. If I have questions or concerns about treatment **I will ask before services are rendered**.

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

_____ _____

Signature **Date**