Healthy Back Chiropractic
1707 Lansing Ave. NE Salem, OR 97301
phone: (503) 589-0700 fax: (503) 586-0255
HealthyBackChiropractic.com

Patient Name: _____ Date: _____

## PATIENT SIGNATURES AND POLICIES

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS**
**AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **HEALTHY BACK CHIROPRACTIC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Intitials _____

**RECEIPT OF NOTICE OF PRIVACY PRACTICES - WRITTEN ACKNOWLEDGEMENT FORM.**

I have been given the opportunity to review and request a copy of the Privacy Practice Notice for Healthy Back Chiropractic.

Intitials _____

**CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initials _____

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**OFFICE/PATIENT AGREEMENTS**

It has been our experience, caring for thousands of patients over the last 10+ years, that those who agree to and understand the following agreements can benefit the most from their care in our office, helping save you time and money.

**Your Consistency of Visits:** Our recommendations for your care are customized to your health goals and your body's needs. You need to keep the recommended number of visits consistent in order to get the best results:

- Meet all your appointments (arrange your activities so you can do this)
- Call us with any emergencies so we can reschedule you
- Ensure that the prescribed number of visits occur for each treatment period
- Come in for care even when you have "the bug"
- Choose an alternate day of the week to make up missed visits
- If you go on vacation, you need to let us know, and increase your visit frequency before and after the vacation in order to maintain your prescribed number of visits

**Missed Visits:** In the event you are unable to make your scheduled appointment we kindly ask you give 24 hours notification when possible. We reserve the right to bill a $42.00 missed appointment fee when notification is not made. If you chronically miss or fail to give notice for cancellations, we reserve the right to suspend treatment privileges.

**Re-Examinations:** In order to monitor your progress, you will receive a re-examination about every three weeks where you will be with one of our health professionals and review your progress since your last examination. New injuries may also require an exam.

**Adjusting Area:** After completing your daily progress, you will go back to the treatment area unless you are scheduled for a re-examination.

**Special Visits:** These visits are anything other than your regular chiropractic adjustments, physical rehabilitation. We do our best to keep your waiting in our office to a minimum; however, we need your help to continue this goal: Please be punctual for these visits.

If you desire to schedule a special non emergency visit such as a nutritional consultation or other special visit, we ask you give us at least one visit notice in advance.

**New Symptoms or Flare Up:** If you experienced any new symptoms or change of health you need to let us know immediately before your next visit.

**Symptom Changes:** As we balance your body, just like a new exercise program, you may experience some soreness, this may happen anytime during your care in our office. If this occurs simply inform us when you come in and we can discuss this with you.

**Return of Supplements or Supplies:** Only unopened and like-new supplements and supplies will be accepted as a return. There is a 10% restocking fee for all returned items. Items will only be accepted for return within 30 days of purchase.

**Upsets:** If you ever have any questions or concerns of any fashion concerning your care in our office, please talk to a staff member immediately so we can answer your questions and help you.

I fully understand and accept these policies.

Initials _____

**PAYMENT(S) POLICY**

**Payment for Services Rendered:** I understand that I am liable for all fees associated with services rendered to me. Full payment is due at the time of service, unless prior arrangements are made. I agree to pay any and all deductibles, co-insurances, co-payments and/or services deemed non-covered by my insurance carrier.

**Accurate Information:** Correct and current information is the responsibility of the patient. Accurate and complete information regarding health history, mailing address, health insurance and billing information are needed. It is the responsibility of the patient to alert Healthy Back Chiropractic if information changes. It is also the patient's responsibility to cooperate with insurance companies as they request information, in a timely manner.

**Returned Checks or Payments:** If a check or electronic payment is returned to us, your account will be charged a $25.00 fee.

**Missed Payment Plan Payments:** If a payment plan payment is not received by the office within 5 days of the agreed upon due date, a $15 fee will charged to your account.

**Payment of Bills:** We will expect you to honor the financial agreement you make with our office; If you find that you cannot fulfill the agreement you have made with us, you need to go to the front desk, and tell one of our staff so that we can discuss with you new arrangements to be made. Methods of payment are Visa, Master Card, Cash, Check and Cash Plans.

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**Billing an Insurance Company**: I have been advised that the doctors, nurses, and therapists at Healthy Back Chiropractic, will bill my insurance company directly for my treatment. I have been further advised that the payment may be sent to me by my insurance company. By signing below, I affirm and attest that I am in no way entitled to this reimbursement for my treatment, and I understand that this money is intended to pay the above mentioned companies and physicians.

Accordingly, it is hereby understood and agreed to again that I have no right, implied or otherwise to said funds as they do not belong to me, and/or the insured party and are intended to pay for my medical care and procedure(s) performed with my informed consent.

Furthermore, in the event I receive a check or checks from the responsible insurance company as payment for my treatment/procedure(s) or the insured's procedure(s), I will immediately or within seventy-two (72) hours contact the appropriate party (the office or the billing department) about the check and return these funds to the appropriate party. I understand that I am ultimately responsible for all medical bills if my insurance company fails to pay, and I will assist Healthy Back Chiropractic with the collection of any funds.

In the event that a check or multiple checks are made payable to me or the insured and is received by Healthy Back Chiropractic or its physicians, I hereby grant the facility and above provider(s) the express permission and limited power of attorney solely and exclusively for the purpose of endorsing said check(s), so that I do not need to return to the facility with the express intent to endorse the funds to the facility / provider(s).

If either party defaults in the performance of any of the terms, provisions, covenants and conditions and by reason thereof, the other party employs the services of an attorney to enforce performance of the covenants, or to perform any service based upon defaults, regardless of initiation of court proceedings, there in any of said events, the prevailing party shall be entitled to recover from the non-prevailing party all of the prevailing party's reasonable attorney's fees and all expenses and costs incurred by the prevailing party pertaining thereto (including costs and fees relating to any appeal) and in the enforcement of any remedy. By signing below, I agree that the sole and exclusive venue for any litigation arising from or related to this Lease shall be in the state courts in Marion County.

Initials _____

Patient Signature _____ Patient Name _____ Date _____

Parent/Guardian Signature _____ Parent/Guardian Name _____

Staff Member Signature _____