COLLINS CHIROPRACTIC CLINIC

Thank you for choosing our office to provide you with chiropractic care.

OFFICE POLICY

APPOINTMENT POLICY:

Based on your r-ray and exam findings the doctor will prescribe a treatment plan. It is important that you follow the treatment plan so you may get the maximum results in a minimum amount of time. We make every attempt to stay on schedule to avoid long waiting periods, to assist us with this, please be on time for your appointment. Please call ahead if you are going to be late or need to reschedule.

FINANCIAL POLICY:

Co-payments and payments for all services are due the same day the service is performed. As a courtesy to you we will file claims with your insurance company. **PLEASE NOTE:** Filing a claim with insurance is not a guarantee of payment and you remain fully responsible for all balances due on your account. **An interest rate of 9% will be added to accounts for past due balances after 30 days.**

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

INFORMED CONSENT FOR CHIROPRACTIC CARE

- I request and consent to the performance of chiropractic examination, adjustments and all other chiropractic procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible), by any of the treating doctors of chiropractic on staff, and/or any licensed chiropractor deemed appropriate by this office.
- I understand that results of treatment are not guaranteed.
- I further understand and am informed that, as in the practice of medicine, in the practice of Chiropractic, there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains and worsening of symptoms.
- I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise their judgment during the course of the procedure which the doctor feels at that time, based on the facts then known, and is in my best interest.
- This consent form covers the entire course of treatment for my present condition, and for any future conditions for which I seek treatment.

Print Patient's Name: _____
Signature of Patient: _____Date: _____
Signature of Parent or Guardian: _____
Witness: _____Date: _____

HIIPA PRIVACY POLICY

A copy of the full HIPPA Policy was made available to me by this office.

Patient's Name: _____
Signature: _____Date: _____