Chiropractic Care Center, NW, P.S., Inc.

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PAYMENT POLICY, PATIENT AGREEMENT AND TREATMENT CONSENT

Welcome to Chiropractic Care Center. We are pleased you chose our clinic. We will do whatever we can to get you back on the road to health as quickly as possible. Please take a moment to read and sign the following patient agreement. If you have any questions regarding this policy, please don't hesitate to ask Dr. Scott or our staff.

OUR PAYMENT POLICY INITIAL: _____

Unless other arrangements are made, it is our policy to collect payment at the time of treatment.

IF YOU HAVE INSURANCE INITIAL: _____

If you have insurance, Chiropractic Care Center will verify and submit your insurance claims for you as a courtesy service; however, ***benefits quoted are not a guarantee of payment.*** If your insurance will only cover a percentage of your bill, you are required to pay your percentage (or copayment) at the time of treatment. If your insurance company does not pay within sixty (60) days from the date of your treatment, you are required to pay the clinic directly. If your insurance does not pay your bills in a timely matter, the clinic may require future treatment be paid for at the time of service. *Any balance remaining after claims have processed will be your responsibility.*

IF YOU HAVE MEDICARE INITIAL: _____

If you have Medicare, you need to know that **Medicare will not pay for the following services:**

- **Initial examinations**
- **Follow-up examinations**
- **Durable Medical Equipment**
- **Massage Therapy**
- **All x-rays**
- **All therapies – heat, ice, hydrotherapy**
- **Maintenance Care**
- **Supplements**

If you have secondary insurance to cover what Medicare does not pay, please let us know so that we can send these charges to the correct company. If Medicare is your only insurance company, you will be responsible for any remaining charges.

Medicare will only pay for approved spinal adjustments.

AUTO ACCIDENT CASES INITIAL: _____

Our office will bill your personal auto insurance carrier under your Personal Injury Protection, or PIP coverage, *regardless of who caused the accident.*

If you are injured by someone else, and you have no PIP coverage to cover your treatment, the clinic may cooperate with you in processing your claim against the person responsible. The clinic may agree to wait for payment of your bill from the proceeds of any settlement or judgment. However, ***you are still responsible for payment***, whether or not you collect from the insurance company or the person who caused the injury. If the clinic agrees to wait for payment, **you and your attorney must cooperate with the clinic and sign an assignment of insurance or settlement proceeds**, so that payment will be made directly to the clinic when your case is concluded.

INJURIES AT WORK INITIAL: _____

If you are injured on the job and your treatment is covered by Washington or Oregon's worker compensation insurance, the clinic will bill the worker's compensation department and no payment by the patient is required at the time of service. ***If your claim is denied by worker's compensation, you will be responsible for your bill.***

LATE FEES INITIAL: _____

Any bills that remain unpaid and have been billed in excess of ninety (90) days will be subject to a billing fee of $5.00 for each billing statement our office is required to send. Any treatment bills remaining after 90 days will also bear interest at the rate of 12% until paid. If the clinic has to hire an attorney or collection agency to collet past due bills, you will be required to reimburse the clinic for any attorney fees, court costs and/or collection charges involved.

AUTHORIZATION TO RELEASE INFORMATION INITIAL: _____

You give the clinic permission to release information about your physical condition to any insurance company or attorney in order to process your claims for payment.

CONSENT TO TREAT INITIAL: _____

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat and manual muscle therapy) are considered to be safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of our clinic to inform our patients of them. Complications could include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burn and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complication is available upon request.

I have read and understand the preceding statements regarding possible treatment side effects. INITIAL: _____
I also understand that there is no guarantee or warranty for a specific cure or result.

I understand that I play a vital role in my own healthcare. Just as a patient can choose to discontinue care at any time, Chiropractic Care Center reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans. INITIAL: _____

I give my permission for the procedure or treatment I am about to receive and consent to the payment policies of Chiropractic Care Center.

_____
Patient Name

_____
Mailing Address

_____
City, State & Zip Code

_____
Home Phone

_____
Cell Phone

_____
Email

_____ _____
Patient Signature Date

By signing this document as a parent or guardian of a minor child about to be treated by Chiropractic Care Center, I authorize treatment for the child and understand I am responsible for payment of the care my minor child receives at the clinic.

Parent/Guardian Signature _____ *Date* _____
(If patient is a minor)