

OFFICE POLICY AND CONSENT TO TREATMENT OF MINOR

APPOINTMENTS

On your first visit the doctor will take a thorough history, and perform a thorough examination, possibly including x-rays. On your second visit the doctor will recommend a treatment plan, laying out the number and frequency of appointments necessary to resolve your problem. You will get the best results, and save time and money, by following this schedule as much as possible. **Please schedule your appointments as far in advance as possible; and should you need to miss an appointment, please do your best to make it up within 7 days.**

PATIENTS WITH INSURANCE

As a courtesy, we will call to verify your insurance coverage, and explain it to you. **Please understand that we are sometimes given incorrect information, and insurance companies have no legal obligation to honor what they tell us.** It is always a good idea to call yourself to double check on your coverage, and to ask for the name of the agent that you speak with. After this is done, and any deductible has been met, we will collect your co-pay at the time of service and wait up to 60 days for your insurance to reimburse the rest.

We file claims monthly. **Should your insurance company deny payment or take over 60 days to pay, you will need to pay any outstanding balance at that time, and resolve the problem with your insurance company. We will provide you with any records you may need to accomplish this, but we cannot fight the insurance company for you.** Your insurance policy is a contract between you and your insurance company. Filing insurance claims is a courtesy provided to you without charge, and in no way relieves you of the responsibility for your bill.

We do not file for secondary insurance, but we will be happy to print out your claims so that you may do so.

ZERO BALANCE POLICY

Our office policy is that all accounts must be current before any further services can be rendered. **After 60 days, any amount due will automatically enter the collection process. Any fees incurred in collecting the overdue amount will be automatically added to the bill.**

CONSENT TO TREATMENT OF MINOR

(I) (We) the undersigned have legal custody/legal guardianship of _____, a minor. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays on him/her by the doctor or authorized staff member. I have had the opportunity to discuss with the doctor or staff member the nature and purpose of these procedures, and any concerns I may have. I understand that results are not guaranteed.

I further understand that although chiropractic treatment is extremely safe, no medical or physical treatment is without risk. I do not expect the doctor to be able to anticipate and explain all possible risks, and wish to rely on his judgment as to the safety and appropriateness of any treatment provided to him/her.

I have read and understand the above, and I consent to all examinations and care as deemed appropriate by the doctor for his/her present condition, and for any future conditions for which he/she may seek care. I realize that I may ask any questions to the doctor either before or after I sign this contract, and I understand that my consent can be withdrawn at any time.

(Signature) _____ (Date) _____