

Financial Policy

Dear Patient,

Waukee Wellness & Chiropractic provides its services directly to you, not your insurance company. You are ultimately responsible for your bill. If you are submitting your own claims, we will provide an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered, provided that your deductible has been met and you pay your co-insurance/co-pay for the time of service. IN the event that we are billing your insurance and a check is mailed to you, you MUST bring the check to the office within (7) days so that we may properly credit your account.

If your insurance carrier has not paid a claim within 90 days of submission, you accept responsibility for payment in full for any outstanding balance and authorize us to use your saved, and protected, card on file to collect full payment. If your balance reaches \$100 and there is no payment plan scheduled, we hold the right to not provide service to you until payment is made. If you discontinue care for any reason, all balances become immediately due and payable in full by you, regardless of any claim submitted. If your account enters into a default status and is considered past due, you assume and agree to pay any administrative fees that may be associated with the collections process. (A default account is deemed where your patient balance is \$100 or more or any amount 60 days past due.)

Patient Signature: _____ Date: _____

Financial Counselor (if applicable): _____

X-Ray

I hereby give my consent to Waukee Wellness & Chiropractic and its representatives to take x-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.

I have read and understood all the above information.

Patient Signature: _____ Date: _____

Informed Consent for Chiropractic Care

A patient, in coming to Waukee Wellness & Chiropractic PC, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if he is aware that such care may be contra-indicated.

Again, it is the responsibility of the patient to make it know, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicated healthcare service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

I understand that if I am accepted as a patient by Waukee Wellness & Chiropractic PC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding Chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

Guardian Signature if patient is under 18: _____

Patient Health Information Consent Form

We want you to know your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require that you read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to ask us and we will provide you with that information.

1. The patient understands and agrees to allow Waukee Wellness & Chiropractic PC to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are know by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____ Date: _____

Guardian Signature if patient is under 18: _____