PATIENT POLICIES

Thank you for choosing Krantz Family Chiropractic & Wellness Center as your health care provider! We are committed to the success of your treatment. The following are statements of our Patient Policies which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information, Patient Policies, and Patient Health Information, Consent and HIPPA Forms before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. WE ACCEPT CASH, CHECKS, CREDIT AND DEBIT CARDS.

INFORMED CONSENT FOR CHIROPRACTIC CARE ____Patient's Initials

A patient, in coming to the Chiropractic Doctor, 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, soreness, soft tissue injury, rib injury, physical therapy burns, stroke or underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he or she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he or she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Doctor. The Chiropractor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by the doctors at Krantz Family Chiropractic & Wellness Center, 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.

Consent to Treat: _____ Patient Signature Date: _____

The information I have given this office is complete to the best of my knowledge. I authorize the doctors and Staff of this clinic to administer such procedures and treatment, as they deem necessary. They have implied no guarantees of cure.

Patient Signature: _____ Date: _____

Consent to Treat Minor Child:

The information **I** have given this office pertaining to is truthful and complete to the best of my knowledge. **I** authorize the doctors and staff to administer such procedures and treatment, as they deem necessary to my child/ward in my legal custody. The doctors have implied no guarantee of cure.

Parent or Guardian's Signature: _____ Date: _____
Relationship to Minor Child: _____ Date: _____
Witness: _____ Date: _____

For Women Only:

The doctor or a staff member of this clinic has advised me that X-rays can be hazardous to an unborn child. At this time and to the best of my knowledge, **I** am not pregnant. **I** consent to having life size x-ray pictures taken.

1. What was the date of the **FIRST DAY** of your last menstrual period? _____
2. Is there any possibility that you may be pregnant at this time? YES NO
3. Type of birth control used at the present time? Birth Control Pills Diaphragm I.U.D
   Other: _____

Patient's Signature: _____ Date: _____
Witness: _____ Date: _____

For Everyone: (Only If Refusal to Take X-Rays) _____ Patient's Initials

I _____ have been explained the severity of my condition and the need for a further diagnostic study. I have refused to have X-Rays taken for whatever reason and acknowledge the fact that the doctor has explained the necessity of the films and will not hold Dr. Krantz or Krantz Family Chiropractic & Wellness Center Responsible for any injury. (If any x-rays are taking at the office they are the property of the office.)

APPOINTMENT SCHEDULING _____ Patient's Initials

Please help us serve you better by keeping scheduled appointments. We charge a $20 missed appointment fee for repeat offenders. Further, understand that non-compliance with your ordered treatment plan may negate our ability to represent your services as medically necessary to your insurance carrier. This is to remind you that in order for the services performed in this clinic to be billed to your insurance carrier, those services must be considered to be medically necessary. Part of satisfying the medical necessity requirements is for this clinic to develop a treatment program that is oriented toward improving your level of functionality to your maximum potential. Our ability to assist you with meeting these goals is based on your commitment to your ordered treatment program. Non-compliance with your treatment plan will interfere with our ability to make the progress that is required by your carrier to establish the medical necessity of the services. If you are non-complaint with your ordered treatment plan you will be discharged from that plan. If this is the case, you will be offered maintenance treatment on a schedule that you can determine. This type of treatment however is not a covered benefit under insurance plans and we will not bill these services to your carrier. Payment for this type of treatment will be your responsibility.

ASSIGNMENT OF INSURANCE BENEFITS ___ Patient's Initials

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Krantz Family Chiropractic & Wellness Center is your responsibility whether your insurance company pays or not.

ASSIGNMENT OF INSURANCE BENEFITS (Cont.) ____ Patient's Initials

We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 90 days, the balance will be automatically payable by you in full within 14 days or be applied to your credit card on file. In the event you suspend or discontinue your program of care prior to the doctor's consent, you are responsible for payment in full of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued. I also understand that interest is charged on overdue (45 days past due) accounts at the annual rate of 16%. The patient will be responsible for all fees incurred for any collection procedures that may be necessary on delinquent accounts.

PATIENT POLICIES Continued

Informing us immediately of any change in your coverage is vital to this office being able to process claims promptly. If your insurance changes, you suffer a work related injury, or are in an automobile accident, our office must be notified before your next appointment. ***If our office is not provided with your insurance coverage before your appointment, visits will be charged cash patient fees until this information is provided.***

REGARDING DEDUCTIBLE AND CO-INSURANCE/CO-PAYMENT OBLIGATIONS ____ Patient's Initials

By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations. All co- insurance and/or co-payments and deductibles are required to be paid under the terms of your contract with your insurance carrier. By law we are responsible to attempt collections of these amounts once they are identified to us on your explanation of benefits. It is the policy of this clinic to bill for all co-insurance, co-payment and deductible amounts. If you have difficulty meeting your full responsibility under the terms of your insurance contract, please contact a member of our billing staff so that financial arrangements for payment can be made.

USUAL AND CUSTOMARY FEES _____ Patient's Initials

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Our fees are generally considered to fall within the acceptable range by most companies, and the charge for each service. This clinic will accept your carrier's allowance as your payment as full provided that you meet any co-insurance, co-payment and/or deductible obligation assigned by your carrier within 60 days of the date of the EOB. This statement does not mean that we accept the carrier's payment as payment in full. Your carrier generally only pays a portion or percentage of the allowed fee for a particular service in accordance with the terms of your benefit plan. Deductible, co-insurance and/or co-payment amounts are your responsibility.

NON-COVERED SERVICES _____ Patient's Initials

Your treatment may involve services that are not covered under your health benefit plan (Ex: Extra spinal adjustment, Heat/Ice, traction, supplements, supports, or therapy). You have the right to deny receipt of these services with a written denial. If you elect to receive any or all services recommended, you will be fully responsible for payment of these services. We make every attempt to verify the limitations of your health insurance benefit plan. As the information we receive is not a guarantee of coverage or benefits, we cannot be responsible for the validity of the information supplied to us by your carrier. You are responsible to verify your coverage limitations based upon your benefit contract. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will immediately be due and payable. I understand that interest is charged on overdue (45 days past due) accounts at the annual rate of 16%. I understand that if my insurance company does not pay for any services rendered, I will be 100% responsible for payment.

WORKERS COMPENSATION AND PERSONAL INJURY ____ Patient's Initials

Worker's Compensation, Auto Accident and Personal Injury usually pay at 100% for Chiropractic Care.

Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for service is due immediately. If an attorney is handling your case, please notify the insurance department at once. **Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an ACTIVE patient and there is a signed attorney lien on file. If you suspend or terminate your care, any fees for services are due immediately.**

BY MY SIGNATURE BELOW, I STATE THAT I HAVE READ AND UNDERSTAND THE POLICIES OF THIS OFFICE AND AGREE TO ABIDE BY THEM. ALL PHOTOCOPIES AND SCAN PAPERWORK OF MY SIGNATURE WILL COUNT AS THE ORGINAL SIGNATURE(S).

_____	_____	_____
Patient Name	**Patient Signature**	**Date**