5446 N. Academy Blvd. Suite 102
Colorado Springs, CO 80918
Tel: (719) 594-0071 Fax: (719)260-1964

_______________________________ _________
Patient Name (Print) Date

____
Patient Signature

Patient Policies and Privacy Agreement

This document constitutes informed consent, treatment policies, and financial agreements for examinations, chiropractic care, medical care, consultations, massages, supportive opinions and authorization to treat by any of the doctors or licensed therapists associated with Springs Family Chiropractic.

Privacy Policy:
_____Any contact information acquired by our clinic will be used only for that individual's medical services and will be secured by all HIPPA security requirements. Medical information may be released by our facility only upon the patient filling out and signing a record request release at our office. Our staff has 30 days to acquire all of a patient's requested medical records for a patient or another health practitioner. Patients must be aware co-pay charges may apply for significant copy requests over five pages as regulated by state laws.

_____Any contact information acquired by our facility on our websites will be kept confidential and not sold. Our facility does reserve the right to contact patients using this contact information for purposes of new services offered, promotional events, emergency situations, and for our own research and surveys. Testimonials submitted may be used for our website and/or promotional purposes. Personal contact information will not be sold to any second parties affiliated with our websites.

New Patient and Treatment Policies:
_____Patients will be expected to receive all services rendered by our facility during our normal business operative hours. If patients request services after-hours or outside our facility, our practitioners reserve the right to charge a $50.00 after-hours-fee to provide a service at the practitioners discretion. All practitioners reserve the right to refer a patient for a second opinion or emergency medical attention of a patient's illness, disease, and/or health status that is outside our scope of practice.

_____New patients will be required to undergo x-rays (unless pregnant or a child), attend workshops and/or educational events, and schedule a Report of Findings (ROF) appointment immediately following their initial consultation and examination. Spouses and/or a support person will be required to attend any workshops and/or educational events including the ROF to become educated alongside the patient during their treatment and rehabilitation time at our clinic. It is our goal to educate the patient and their accompanying family member/spouse/support person in order to partner with the patient to help them attain optimal health and achieve their personal health goals. X-rays, workshops and/or events, and the ROF fees are included in the initial consultation and examination fees and will not be unbundled from the initial fee.

_____The patients are responsible for keeping scheduled appointments, performing prescribed home rehabilitation, office rehabilitation, and obtaining a progress x-ray after 4-5 months of care.

Non-compliance Policy:
_____Any patients who do not comply with our prescribed treatment plans must not expect to achieve their requested health goals, experience symptom relief, or have access to continual medical and wellness services.
Examples of non-compliance may include any patient being treated for a personal injury due to a motor vehicle accident or workman's compensation with gaps in care and/or continually missing scheduled appointments to include massage therapy or consultations.

______These patients may be discharged from our practice and their insurance adjusters contacted and notified of the changes.

Scheduling and Cancellation Policy:
_____Repeated failure-to-show for scheduled chiropractic appointments may result in a $50.00 cancellation fee.
Any patient seeking a massage appointment will be required to submit their credit card information to be held on file to secure their appointment time. If the patient does not cancel prior to **24 hours** of their scheduled massage **or** misses their appointment completely, their card on file will be charged **$50.00**.

Payment Policies
_____ I understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. I understand Springs Family Chiropractic is out-of-network for all insurance companies and that I will pay at time-of-service. If utilizing insurance, I understand that I will either provide the facility copies of my ID, SS number, and insurance card for verification purposes or I may receive a superbill from the facility and may submit insurance claims on my own.
_____ I understand special discounts may apply when a zero balance is maintained. If I suspend or terminate my care and treatment, all fees for services rendered to me will be immediately due and payable.

5446 N. Academy Blvd. Suite 102
Colorado Springs, CO 80918
Tel: (719) 594-0071 Fax: (719)260-1964

_______________________________ _________
Patient Name (Print) Date

____
Patient Signature

Patient Policies Continued…

This document constitutes informed consent, treatment policies, and financial agreements for examinations, chiropractic care, medical care, consultations, massages, supportive opinions and authorization to treat by any of the doctors or licensed therapists associated with Springs Family Chiropractic.

Payment Policies Continued…

_____ I understand and agree that all payment plans for treatment must be previously arranged with the Doctor to include massage, chiropractic, and nutrition packages. If payment plans are arranged, interest will be determined by Springs Family Chiropractic.

_____ I understand and agree that if I pre-pay for any treatment plans and decide to terminate my care after 30 days, no refund will be issued for any remaining treatments, services, or rehabilitation equipment.

_____ I do authorize Springs Family Chiropractic to endorse and deposit third-party checks for conveyance of credit to my account. Any over-payments will be refunded.

_____ I understand it is not legal to waive insurance deductibles. Therefore, I agree to make monthly and appropriate payments (10% balance due) if I am at any time unable to maintain a zero balance on my account.

Car Accident/Workmen's Compensation Payment Policies

_____ I understand that health and accident policies are an arrangement between an insurance carrier and myself. As such, I will provide any necessary insurance policy numbers, contact information, and forms necessary for collection from the insurance company. Springs Family Chiropractic will assist me with reports and answer administrative questions; however, I am responsible for collection from the insurance carrier.

_____ Do you want us to bill your insurance please circle one Yes or No

_____ I understand and agree that Springs Family Chiropractic has authorization to receive direct reimbursement/ payment for all my medical services received in the Chiropractic clinic from my insurance or third party at fault insurance company. By initialing here, I agree and understand that the insurance company will mail or directly pay Springs Family Chiropractic on my behalf.

_____ I do hereby give permanent and irrevocable LIEN to Springs Family Chiropractic on any settlement, claim, judgement, or verdict as a result of accident/illness and authorize my attorney/insurance carrier to pay directly Springs Family Chiropractic such sums as may be due and owing for services rendered to me. I also authorize the withholding of such sums from any settlement, claim, judgment, or verdict as may be necessary to protect Springs Family Chiropractic adequately.

_____ I understand that all personal injury claims (i.e. car accident and workman's compensation) payments are due and payable at the time of service unless third party terms that apply are acceptable. I agree that I am responsible for any unpaid balances.

_____ I understand that if I am currently or in the future receiving care for personal injury from motor vehicle accidents will have associated third party billing at our insurance rates. Billing procedure are done in conjunction with third party reimbursement to appropriately cover prolonged reimbursement periods for services rendered in personal injury cases. I will be given the option and privilege to pay for any services out of pocket if I do not wish to use third party insurance or recommended attorney. If you do not have an attorney payment and the insurance company pays you the patient directly, full payment is due in five business day after your receive your settlement.

Patient Records and Chiropractic Lien Agreement for All Patients

I, __________________________________ do hereby authorize Springs Family Chiropractic to furnish my attorney/insurance carrier with a full
Patient Name
report of my case history, diagnosis, treatments, exams, and prognosis of myself in regard to my accident/illness which occurred or began on _______________________.
Date of Injury

_____ I hereby give a lien to Springs Family Chiropractic on any settlement, claim, judgment, or verdict as a result of said accident/illness and authorize and direct you, my attorney/insurance carrier, to pay directly to Springs Family Chiropractic Clinic such sums as may be due and owing them for services rendered to me and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect Springs Family Chiropractic adequately.

_____ I fully understand that I am directly and fully responsible to Springs Family Chiropractic for all medical bills submitted by them for services rendered me and this agreement is made solely for Springs Family Chiropractic's additional protection and in consideration of my awaiting payment. I further understand that such payment is not contingent on any settlement, claim judgment, or verdict by which I may eventually recover said fee.

_____ In the event a settlement or judgment has been reached, payment is required five business days from date of settlement decided.

Attorney's Only Representing Patients at Springs Family Chiropractic

5446 N. Academy Blvd. Suite 102
Colorado Springs, CO 80918
Tel: (719) 594-0071 Fax: (719)260-1964

________________________________ __________
Patient Name (Print) Date

____
Patient Signature

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named Springs Family Chiropractic lien.

Attorney Name (Please Print):____

Attorney Signature:____ Date:____

(Please date, sign, and return one copy to the Chiropractic Clinic to verify receipt. Keep one copy for your records.)

Patient Policies Continued…

This document constitutes informed consent, treatment policies, and financial agreements for examinations, chiropractic care, medical care, consultations, massages, supportive opinions and authorization to treat by any of the doctors or licensed therapists associated with Springs Family Chiropractic.

Assignment of Benefits

I authorize ____________________ Insurance Company to pay and mail checks directly to Springs Family Chiropractic or the providing doctor.

Treatment and Consent

I, ______________________________________ have read and fully understand the above policies concerning exams,
Patient Name
treatments, and payments. All questions pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept care on this basis.

____ ________________________________ ________________________________
Signature Date Witness

Complete if Patient is a Minor Child:
I, ______________________________ being the parent or legal guardian of _________________________________
Parent or legal guardian name Patient

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive health care.

______________________________________ ________________________________ ___________________________
Signature Date Witness