

INSURANCE BENEFITS – PAYMENTS TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us. Our Facility & staff are not responsible for what a payer and/or representative may tell us, including mis-quoted benefits, coverage and liability.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and /or additional reports or documents sent for your benefit may result in an additional filing medical report charge, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet the cost of service.
4. All account balances, including automobile claims must be paid within **90 days** of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, and judgment. If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory “Time of Service Discount” is offered to anyone who pays for services the day they are rendered. The “TOS” is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, psychological counseling services and massage therapy.
6. A service charge is computed by a periodic rate of 1 ½ % per month- 18% per annum & is added to all balances owed 60 + days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$25.00 charge.
7. Note: Missed appointments that are not canceled at least 24 hours prior to appointment time will be subjected to a Missed Appointment Fee at the Office’s discretion. The Fee will be the patient’s sole responsibility.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document and fully understand and have all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient Signature (if minor, parent must sign) Date

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, "Chiropractor" refers to Dr. Heather Wright, BS, DC, CCEP.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restricts, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PERSONAL INFORMATION CAN BE GIVEN ONLY TO THOSE YOU LIST

1. Please list the **name** and **relation** and **phone number** of any person(s), if any, whom we may inform about your general medical condition, your diagnosis, prognosis **AND APPOINTMENTS**. (i.e. spouse, sibling, school nurse, or other.)

2. Please list the **name** and **home number**, if any to whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

2. If other than your home address, please print the primary address of where you would like all correspondence from our office sent.
3. If other than your home phone number, please print the telephone number of where you want to receive calls about your appointments, lab and x-ray results or other health care information.
4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTAL"

By my signature below I give Wright Chiropractic permission to contact me, and/or leave me messages using any of my contact information collected in my paperwork unless specifically excluded here: Do not contact me at: _____

Signature of Patient /Representative

Printed Name of Patient

Date

INFORMED CONSENT
Wright Chiropractic Health Center, PA
702B Eureka St
Weatherford, Tx 76086

PATIENT NAME _____

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment. Extremity adjustments may also be performed if your case warrants.

◆ **The nature of the chiropractic adjustment.**

The doctor will use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

◆ **The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, nausea, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

◆ **The probability of those risks occurring.**

Muscle soreness, tightness, and general discomfort is the most common reaction to the adjustments, especially in the beginning of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

◆ **Ancillary treatment.**

In addition to chiropractic adjustments, the Doctor may use additional following treatments:

Electrical Muscle Stim	Flexion/Distracton
Ice Therapy	Nutritional Counsleing
Heat Therapy	Massage
Ultrasound/Iontophoresis	Exercise and Stretching Rehab
Cold Laser Therapy	Balance and Proprioception Training
Traction	
Kinesiotaping	

These treatments involve the following additional significant risks:

Potential Burns, injuries from falls/loss of balance, muscle injuries, frostbite

◆ **The availability and nature of other treatment options.**

Other treatment options for your condition were discussed in your Report of Findings and may include (but are not limited to:)

- ◆ Self-administered, over-the-counter analgesics and rest

- ◆ Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
 - ◆ Hospitalization with traction
 - ◆ Surgery
- ◆ **The material risks inherent in such options and the probability of such risks occurring include:**
- ◆ Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
 - ◆ Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
 - ◆ Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
 - ◆ The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mis- hap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.
- ◆ **The risks and dangers attendant to remaining untreated.**
 Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high. Eventual Surgery May arise from lack of treatment or failure to follow-through with recommendations.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Heather Wright and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

 DATE

 Printed Name

 Signature

 Signature of Parent or Guardian (if a minor)

Wright Chiropractic Health Center

702B Eureka St
Weatherford, TX 76086
817-594-5944



I give permission for the following people to sign paperwork for my child, _____, when I am not present:

1)

2)

3)

4)

Legal Guardian: _____

Signature

Printed

Date: _____