AMBERWOOD TERRACE
CHIROPRACTIC

Office Policies

_____

Patient Name

Our Mission

To help as many people as we can in our lifetime – especially children.

The Doctor has already mentioned that Chiropractic care is based on the following principles:

- The body is a self-healing, self-regulating organism…it is designed to heal itself.
- The nervous system is the central "computer system" which runs the body.
- Any interference to the function of the nervous system would then necessarily cause the body to malfunction and cause ill health.
- Our purpose is to restore "law and order" in your nervous system to ultimately promote optimal health.

Referrals

Since most subluxations DO NOT produce symptoms, we believe that **everyone** should be checked. We would like you to know that we offer certificates for you to share with family and friends (don't forget kids) of our patients. Certificates are available at the front desk. The greatest honor a patient can give to their doctors is a referral of their family and friends. We promise to give your loved ones the same quality, love and attention that you receive. We want to thank you in advance for your confidence you have in our office.

Appointment Policy

Office visits are scheduled according to the severity of your condition and the program of Chiropractic care that the doctor believes is best for you. Frequency of care is generally more intensive at the onset of your Chiropractic program. The Doctor is working to alter your body's bad habits…each adjustment builds on the last. Because your condition requires numerous appointments over the next few weeks or months, the doctor has designed a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so the doctor asks that each patient assume the responsibility of strict adherence to the **appointment program** as **it is designed for optimum results for your benefit.**

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the services. If, for any reason, you are unable to keep an appointment, please telephone immediately to reschedule that visit**. It is the patient's obligation to make up cancelled or missed appointments within 7 days** of any cancellation.

Remember, healing and spinal correction take time. If at any time during your care you have concerns, or do not feel that you are responding as well as you expected, please, discuss it with the doctor. He wants you to get the most from your Chiropractic care!

Initials _____

Upon Arrival

We want all of our patients to experience a relaxed and calming atmosphere when receiving care. For this reason, we ask you to turn your cell phone off, or at least on silent mode upon entering the office. Make yourself comfortable in our reception area and one of our staff members (determined by the type of treatment you receive) will escort you to that specific treatment area.

Initials _____

Missed Appointment Policy/Fee

Our policy on missing appointments is simple, **YOU DON'T!** Sounds a bit harsh but the doctor is serious about your recovery. A missed appointment takes you off your adjustment schedule and must be rescheduled as soon as possible. If you are running late (traffic, flat tire, etc.) please call to see if the schedule permits for you to still see the doctor. If necessary, you will be rescheduled.

If you are 15 minutes late for an appointment and have not contacted the office prior to the scheduled appointment time to make other arrangements, the appointment is considered a MISSED appointment. Each patient will be allowed one missed appointment with no penalty, however after the first missed appointment, **each following missed appointment will be billed at $50.00.**

Initials_____

Interruption of Care

In the unlikely event it is necessary to discontinue chiropractic care, for any reason, any outstanding balance becomes due immediately.

Initials _____

X-Rays

When X-Rays are taken at ATC, the information on them belongs to the patient, but the films themselves are the property of this office as they are part of your permanent record. You have the option to request a disc with your X-Rays on it. The first disc will be complimentary, each disc after will be charged at $5.00. This disc is for you to keep, please do not return it to ATC. **Patients wishing to check out X-Rays must have a $0 ledger balance in order for the films to be released.**

Initials _____

Financial Policy

We accept Cash, Check, and Debit/Credit Cards. There is a **service charge of $35** for any returned checks. Payment is expected at the time of service, or for your convenience, payment may be made at the end of the week for all services received during that week of care.

- This office operates as a CASH practice (ATC is not in network with any insurance companies, therefore ATC does not accept insurance), and is also" non-par" with Medicare. Payment is expected at the time of service.

- As a non-par Medicare provider, ATC will handle all billing of claims to Medicare. Patients will be held financially responsible for all fees as outlined in the Care Plan /Payment section of this document for services provided by ATC and will be reimbursed directly by Medicare should Medicare chose to reimburse for any services, based on Medicare guidelines.

- **Patients with Chiropractic insurance benefits will be responsible for filing all claims on their own. ATC will not file any insurance claims.**

We expect you to honor the Care Plan/ Payment agreement you make with our office. If you find that you cannot fulfill the agreement you make with us, please inform our staff immediately so new arrangements can be made.

Patient (or guardian) Signature: _____ Date: _____

ATC Staff: _____ Date: _____

Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize Amberwood Terrace Chiropractic ("the Practice") and its licensed doctors and assistants to undertake an examination and provide an evaluation and treatment plan that may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Amberwood Terrace Chiropractic doctors to make those decisions about my care, based on the facts that they believe are in my best interest.

As a part of the analysis, examination, and treatment, I am consenting to services that may include: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies and other procedures as necessary. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, I understand that the Practice doctors will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They will also explain the cost of my proposed care (or provided me with a current fee schedule).

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor. Some types of manipulations 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 Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

The availability and nature of other treatment options may include self-administered, over-the-counter analgesics and rest, medical care and drugs such as anti-inflammatory, muscle relaxants, and pain-killers, hospitalization or surgery. If one chooses to use one of the above noted "other treatment" options, one should be aware that there are risks and benefits of such options, and I understand that I may wish to discuss these with my primary medical physician.

The risks and dangers to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility, setting up a pain reaction and further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

This document is intended as a general, broad-based consent applies to any and all contemplated procedures. I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.

I understand and accept that:

1. l has the right to withdraw from or discontinue any treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve making judgments based upon the facts known to the doctor during my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the Practice's examination, evaluation, and proposed course of care and treatments.

_____ _____

Patient's Printed Name Patient's (or guardian) Signature

_____ _____

ATC Staff Signature of Doctor

AMBERWOOD TERRACE
CHIROPRACTIC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICIES

For use and/or disclosure of Protected Health Information (PHI)
& to carry out Treatment, Payment, and Healthcare Operations

_____ hereby states that by signing this Consent, I acknowledge and agree as follows:
Patient Name

1. ATC's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for ATC to provide treatment to me, and it is also required for ATC to obtain payment for that treatment and to carry out its health care operations. ATC explained to me that the Privacy Notice would be available to me in the future at my request. ATC has further described my right to obtain a copy of the Privacy Notice before signing this Consent and has encouraged me to read the Privacy Notice carefully before my signing this Consent.
2. ATC reserves the right to change its privacy practices described in its Privacy Notice in accordance with applicable law.
3. ATC's "Notice of Privacy Practices" is also provided in the front lobby. I may also request a copy from this office at any time via US Mail or email.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understood the preceding notice, and all of my questions have been answered to my complete satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Parent/Guardian ATC Staff

_____
Date Signed