White Sands Chiropractic, Inc Office Policies

Please Read and Initial beside each paragraph

_____**AUTHORIZATION FOR CHIROPRACTIC TREATMENT**: I hereby authorize Dr. Erik Persiani, D.C., and the staff of White Sands Chiropractic to perform diagnostics tests and render care considered therapeutically necessary on the basis of findings during the course of my treatment. A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with 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 health care if he 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 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-duplication health care service. Your Doctor of Chiropractic Physician is licensed in a special practice and is available to work with other types of providers in your health care regime. I am authorizing Dr. Erik Persiani, D.C., to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. As of the date stated below, I have the legal right to select and authorize health care services for the patient named below. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify White Sands Chiropractic, Inc.

____ **CONSENT FOR TREATMENT AND X-RAY**: I acknowledge and understand that the doctor will provide a history and examination today and this MAY include NECESSARY x-rays. The Chiropractic Physician is hereby authorized to complete this examination and treatment.

_____**HIPAA/PRIVACY**: The patient understands and agrees to allow White Sands Chiropractic, Inc to use their Patient Health Information for the sole purpose of treatment, payments, healthcare operations, and coordination of care. We want you to know your Patient Health Information is going to be used in this office and your right concerning these records. If you would like to have a more detailed account of our policies and procedures concerning the policy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

_____**FINANCIAL POLICY**: It is the policy of White Sands Chiropractic, Inc that all balances will be paid in full at time of service unless other arrangements have been made. We accept cash, check, MasterCard, Visa, Discover and American Express.

_____**GROUP/INDIVIDUAL INSURANCE**: Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We offer a complimentary coverage verification, however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy

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to you, our office will complete and file any necessary insurance forms at no additional charge. It is to be understood and agreed that any service rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays. If your insurance does not respond within 60 days, or if you suspend or terminate care, any fees for services will be due immediately. You may also pay the full amount due each visit, qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

_____**ASSIGNMENT AND RELEASE**: I assign directly to White Sands Chiropractic, Inc all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment/and or to receive medical information pertaining to my case in the facility.

I hereby certify that I understand and agree to the policies set forth by White Sands Chiropractic, Inc.

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Patient or Parent/Legal Guardian (Print) **Signature** **Date**

_____ ***FEMALES RECEIVING X-RAYS***: To the Best of my knowledge, I am not pregnant, neither confirmed or suspected.

Date of last menstrual cycle:___________ Method of birth control: ___________________________

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Patient/Parent or Legal Guardian (Print **Signature** **Date**