Carter Chiropractic & Laser Pain Solutions

Patient Name: _____ DOB:_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, the undersigned, have read the ***Notice of Privacy Policies*** of **Carter Chiropractic & Laser Pain Solutions** and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____
Patient Signature Date

_____
Parent/Guardian Signature (if patient is under 18 yrs of age)

FINANCIAL POLICY SUMMARY

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible & choose a pre-payment plan, auto-debit plan or "prompt payment" option.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of November 8, 2021 our office will be unable to extend any type of discounts other than those listed above.

_____ _____
Patient Signature Date

_____
Parent/Guardian Signature (if patient is under 18 yrs of age)