Terms of Acceptance / Authorization Form

We are committed to providing you the best possible care and we are pleased you have chosen our office for your health care needs. Your clear understanding of your care in our office, the handling of your Protected Health Information, and our Financial Policies are important to us. Therefore, we will do our best to make sure you are informed of our policies. Our Doctor and Staff will do our best to make sure you understand your chiropractic care and our Office Manager will discuss and make sure you understand your financial obligations.

As our valued patient, we request that you give us accurate and updated information regarding your health, your insurance information, and any other information you feel we should know about to better understand your situation. We look forward to serving you.

I do hereby authorize Prairie Family & Sports CHIROPRACTIC, P.A. to release my medical information, including medical records and x-rays, and any other necessary information needed to process my insurance claim. This is to serve as a long-term authorization card.

Print Patient Name: _____

Signature of Authorized Person: _____ Date: _____

I authorize payment of insurance benefits directly to Chad M. Eischens, D.C. or Prairie Family & Sports CHIROPRACTIC, P.A. I understand and agree to allow this chiropractic office to use my Patient Health Information (P.H.I.) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care or products and/or supplies regardless of insurance coverage or contracts. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on remaining balances over 30 days old at the annual rate of 18% (1.5% monthly billing fee). This authorization is to apply to all occasions of service until it is revoked in writing.

Patient Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Office Policies:

<u>Payment</u>: We do expect payment for deductibles, co-pays, co-insurance and items not covered by insurance to be made on the same day as the service. We do offer a Same Day Cash Discount. Prepaying is acceptable. We accept Cash, Check, Visa, and Mastercard. In cases of Financial Hardship you can discuss a Payment Plan with our Office Manager. We want to work with you so you can afford the care you need. Our Office Manager will discuss our fees with you.

<u>Treatment</u>: In order for you to receive the best results possible from your chiropractic care, it is important to maintain your treatment schedule discussed by your doctor. If you are ever unable to make your appointment, please contact us and give us plenty of notice, so we can get you rescheduled for a more convenient time. Your care is important to us and we value your time. We want you to get the best results possible from your care.

(OVER)

Consent for Additional Uses or Disclosures of Protected Health Information

I authorize Prairie Family & Sports CHIROPRACTIC, P.A. to use or disclose my Full Name for purposes of the following areas:

Sign-In Sheet: **We do request that all our patients sign in at each visit. This is the only way to keep our records updated with any new information. This information is only used in our office and the names on this list are not shared with anyone but our staff and are not used for any marketing purposes.**

Referral Program: **Referral Programs are a wonderful part of our practice. It is very rewarding when a patient is able to refer a friend or loved one and see them get help through chiropractic care. We like to thank and acknowledge our valued patients who make referrals to our clinic. We appreciate their trust. We use our Referral Board and Referral Thank You cards to do this.**

I have read the above-mentioned areas of use / disclosure of my Protected Health Information and I agree to the use of such information to the extent listed above. I have also read and acknowledged this chiropractic office's Notice of Privacy Policies, and fully understand that this office will only use the minimum required amount of P.H.I. to fulfill its needs.

Patient Name: _____

Signature of Patient / Guardian: _____ Date: _____