



Dr. James C. Gardner, DC

1220 East 17th Street  
Idaho Falls, ID 83404  
Phone: (208) 529-1919  
Fax: (208) 552-9447

---

## **Notice of Consent to Treatment, HIPAA and Financial Agreement**

Please sign at the bottom.

**PATIENT NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

### **CONSENT TO TREATMENT**

I hereby give consent and approval for myself/my child to participate in and be provided with diagnostic tests, evaluation, therapy procedures including massage therapy, and treatment by Dr. James C. Gardner, DC and/or staff of Grand Teton Chiropractic, P.C. I understand and hereby give permission that chiropractic treatment(s) and ancillary physiotherapy procedures will require the Provider(s) to have direct skin access to the patient's body, as deemed necessary by the provider. Furthermore, I hereby waive, release, and forever discharge Grand Teton Chiropractic, P.C., Dr. James C. Gardner, D.C. and/or staff, representatives, or employees of Grand Teton Chiropractic, P.C. from any and all claims of damages, injury, or loss to persons or property.

### **PATIENT FINANCIAL AGREEMENT**

I hereby request payment of authorized insurance benefits when applicable, to be made either to me or on my behalf to GRAND TETON CHIROPRACTIC, P.C. for any services furnished to me, or my dependent, by GRAND TETON CHIROPRACTIC P.C. I understand Dr. Gardner is an in-network provider with MEDICARE. I acknowledge liability for all medical expenses incurred whether or not the expenses are covered by insurance. Should any such expenses remain unpaid, such as insurance deductible, policy limits or exclusions, I agree to pay any amount remaining owed to GRAND TETON CHIROPRACTIC, P.C. This includes late fees, attorney's fees, and collection fees.

Each patient's co-payment is payable at the time of service. Where there is no insurance coverage, *payment is due on the date of service* unless other arrangements have been previously made. On all accounts more than 90 days past due interest will accrue at the rate of 1.5% per month on the remaining principal balance. Credits that may accrue on accounts from insurance write-offs or non-use by the patient are forfeit to the clinic after one year of said credit being applied to account. Inquiries regarding credits on account will be provided when requested. I acknowledge receipt of the extended financial agreement.

### **NOTICE OF PRIVACY SUMMARY**

I authorize any holder of medical information about me/my child to release to the health care financing administration and its agents any information needed to determine these benefits of the benefits payable for related services. I further authorize the release of medical information to other medical, chiropractic, legal or other entities when deemed necessary.

**I acknowledge that I was provided with the Notice of Privacy Practice (HIPAA) of the Chiropractic office named above.**

---

**SIGNATURE OF PATIENT / RESPONSIBLE PARTY**

---

**TODAY'S DATE**