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chiropractic

Welcome to Our Office

Live Well Chiropractic PLLC offers a unique service to our clients and the community. Our efforts are to make your experience here helpful, friendly, and informative. Today we will determine if we can help you. In order to do that, we may need to do the following;

- Review your health history
- Perform an examination
- Perform an x-ray examination
- Explain how chiropractic can help you

When a person seeks chiropractic health care and we accept for such care, it is essential for both to be working towards the same goal. Chiropractic has one goal. It is important for you to understand this goal and the method by which it will be attained.

Chiropractic recognizes that the most basic quality of life is the striving to stay alive and function at a level of optimum efficiency. Our bodies perform this function innately. A properly functioning nervous system is essential to maintaining optimum function in the body. When a vertebra (spinal bone) is misaligned and interferes with nerve function, this is called subluxation. A disc subluxation interferes with the body's ability to maintain proper function. Our goal is to locate, analyze, and correct these vertebral subluxations to restore a better nerve supply to all parts of the body. The method of correction is by specific adjustments of the spine to address these vertebral subluxations, thereby allowing the innate healing abilities of the body to work as nature intended. For some people this happens quickly, for others, more slowly. For some, the repair and maintenance is complete, for others it is only partial.

OUR GOAL IS TO CORRECT VERTEBRAL SUBLUXATIONS, WHICH ALLOWS FOR A BETTER EXPRESSION OF HEALTH.

I, _____

have read and understand the above statements and undertake in chiropractic care on this basis.

Signature _____ **Date**_____

COMPLETE BY LEGAL GUARDIAN IF PATIENT IS A MINOR

Print Child's Name _____

I,_____

being the parent or legal guardian of the aforementioned child, have read and understand the above statements and grant permission for my child to receive chiropractic care on this basis.

Signature _____ **Date**_____

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Our Office Policies

Welcome to Live Well Chiropractic! Congratulations on beginning your quest for improved health and better quality of life. Below are a few policies which were specifically designed to enable you to achieve the optimum results from your treatment plan. Please review these policies.

APPOINTMENT POLICY:

For your convenience, multiple appointments either have been or may be scheduled in order to facilitate office visits into your daily routine and minimize wait times.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts, and not the days. Therefore, if you are unable to keep an appointment for any reason, we require you call us immediately to reschedule your visit. It is your obligation to make up missed appointments within seven days of cancellation. If you fail to cancel within 24 hours, we reserve the right to charge a $50 missed appointment fee. This also includes massage appointments.

INSURANCE POLICY:

We will verify your insurance benefits. We will bill your insurance for you as a courtesy. We will correct any errors we have made when there is a billing dispute. We will provide guidance in getting your bills paid. Please know and understand your insurance coverage. Please pay your deductible, coinsurance, or copayment at the time of your treatment. Please read and keep your explanation of benefits statements from your insurance. Please follow up promptly with claims that are not paid by your insurance company, or you will be billed directly for them. Whether you are paying cash or using insurance, you are always responsible for your bill.

FINANCIAL POLICY:

All payments are expected at the time of service or at the end of each week. Patient's balances may not exceed $100 at any time. Balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. We reserve the right to charge for missed appointments and those cancelled without 24 hour notice, a fee of $50. No Refunds.

Signature _____ **Date**_____

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Credit Card On File Agreement

Live Well Chiropractic, PLLC **practice policy now requires keeping a Guarantor credit or debit card on file for every patient account** as a convenient method of payment for the portion of services insurance doesn't cover, and to collect for services for which you are liable. Keeping a credit card on file will eliminate waiting for statements, mailing checks, or calling with credit card payments.

This agreement is required – if you choose to decline this authorization or do not maintain a valid and current credit card on file, billing and unpaid balance fees, and further actions will be implemented as outlined in the practice Financial Policy.

Your credit card information will be kept confidential and secure.

Payment terms:

- Co-pays and any other out-of-pocket expenses incurred during patient visits will be charged to the credit card on file after the completion of the appointment (unless another form of payment is agreed upon and paid at the time of service).
- Out-of-pocket charges incurred between visits will be charged to the credit card on file immediately (unless another form of payment is agreed upon and promptly paid). Please understand that out-of-pocket charges also include no show/late cancellation fees.
- If your participating insurance policy is subject to deductibles and/or co-insurance that cannot be collected on the date of service, Live Well Chiropractic, PLLC, will charge your credit card on file once your carrier provides and Explanation of Benefits (EOB) to the practice designating your financial responsibility for the claim. It is your responsibility to notify the practice if a secondary insurance, HSA, HRA, or other payment is expected to be paid directly to the practice to cover outstanding balances in order to avoid being automatically charged. Charges of this type will only be made to your credit card without your prior notice if the claim was adjudicated normally. Your insurance carrier will also continue to provide you with an EOB that explains how much of your office visit they paid and how much you are responsible to pay.
- If the total amount to be charged is over $100.00, you will be notified of the exact amount due before charging your card on file. It is expected that you will respond upon receipt of the notification indicating how you would prefer the charge to be settled. If no response is returned the credit card on file will be charged.

Any cancelled or missed appointments without a 24-hour notice will result in the credit card on file being charged the late cancellation/no show fee of $50.00.

In the event of a declined charge, you will be asked for a new credit card number and/or payment before continuing treatments.

I, the undersigned, authorize Live Well Chiropractic, PLLC to charge all patient charges that are my financial responsibility, as outlined above, to the following credit or debit card:

Visa **Mastercard** **Discover** **American Express** **CARD NUMBER:** _____

Exp. Date: ____ /_____ **Security Code (CVC):** _____ **Billing Zip:** _____

Card Holder Name _____

Signature _____ **Date** _____

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Notice of Privacy Practices Acknowledgement

I ACKNOWLEDGE THAT:

- I received a copy of the Medical Practice's Notice of Privacy Practices.
- I was able to review the Medical Practice's Notice of Privacy Practices at the place where I received health care services.
- The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read said Notice of Privacy Practices.
- I know that I can ask for a copy of the Notice of Privacy Practices for me to take and keep.
- I was able to view the Notice of Privacy Practices on the first day I received health care services after June 14, 2010.
- If I came in for health services in an emergency treatment situation, I was given the opportunity to view the notice as soon as was reasonably practical after the emergency treatment situation ended.

Signature _____ **Date**_____

(Patient or Patient's Representative)

To be completed by Medical Practice

If an acknowledgement was not obtained, the Medical Practice must document, in the space provided below, its good faith efforts to obtain the acknowledgement and then the reason why the acknowledgement was not obtained.

_____

_____

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_____

Signature _____ **Date**_____

(Medical Practice Representative)