Grand Teton Chiropractic, P.C.

Please Initial Each Section and Sign 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. Furthermore, I hereby waive, release, and forever discharge 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 patients 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.

MASSAGE ATTENDANCE AND PAYMENT POLICY

_____You may cancel a massage appointment with no charge any time before the office closes on the business day preceding (before) your appointment date. Same-day cancellations that are called in will be charged 50% of the scheduled service price. If you do not call or otherwise notify the office that you are cancelling on the day of your scheduled massage and/or if you do not show up for your scheduled appointment, you will be charged full price (100%) for the scheduled service. As a massage patient, you recognize that your credit card number will be obtained and securely stored in our system when you schedule a massage appointment. Further, you accept this policy and acknowledge that cancellation charges will be applied to your credit card when applicable. Due to the large block of time a massage takes and the limited time available for massage services, we have instituted this policy to encourage patient's punctuality and commitment to scheduled massage services.

MASSAGE ETIQUITE

_____ I agree to communicate with the massage therapist any time I feel uncomfortable or compromised and I understand I may stop the massage if I feel it is necessary. I understand that the therapist has the right to stop the massage at any time they feel uncomfortable or compromised as well. I understand that this massage is in no way sexual and that the therapist is only to provide therapeutic massage.

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 (HIPPA) of the Chiropractic office named above.

_____ _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY **TODAY'S DATE**

Rev. 1/29/2019