

## Office Policy

In order to provide you the best possible chiropractic wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

*It is our greatest pleasure to welcome you to our office. Our goal is to serve you with exceptionally friendly and prompt service, and to provide you and your family with the best health care available.*

**CLINIC HOURS:** Currently, our day is divided into treatment hours and exam/consultation hours. Adjustments/massage will be scheduled during treatment times only, and exams/ consultations will be scheduled during those times only. Our office is open for business 8:00 am to 12:00 noon & 2:00 pm to 6:00 pm Monday through Thursday.

**LATE AND MISSED APPOINTMENTS:** If you are unable to keep your chiropractic appointment at the scheduled time, *please contact us 24 hours prior to your appointment to reschedule and avoid a \$25 missed appointment fee.* If you are unable to keep your massage therapy appointment at the scheduled time, *please contact us 24 hours prior to your appointment to reschedule and avoid a \$25 missed appointment fee.* If you are late for your massage appointment, in order to remain on schedule out of courtesy to other patients and the massage therapist, your massage appointment will be shortened by the amount of time you are late.

**PAYMENT POLICIES:** Payment is due at the time of service in order to receive the time of service rate. If you do not have health insurance that covers chiropractic care, and would like information on the following, please check the appropriate box:

<input type="checkbox"/> Clergy/Full Time Ministry	<input type="checkbox"/> Senior Citizen, Severely Disabled
<input type="checkbox"/> Full Time Student	<input type="checkbox"/> Low Income (\$30,000 or less per year)
<input type="checkbox"/> Employee/Friend/Family	<input type="checkbox"/> 2 or more immediate family members seeking chiropractic care.
<input type="checkbox"/> Time of Service Discount	<input type="checkbox"/> CareCredit

### **NOTICE OF PRIVACY PRACTICES**

- By my signature below, I signify that I have received a copy of the Notice of Privacy Practices for Protected Health Information describing my rights regarding my medical records at ChiroTime, P.C..

### **ASSIGNMENT & RELEASE:**

- I authorize release of information to family physicians & employer.  
 I authorize release of information to insurance companies  
 I authorize the taking of photographs and x-rays to be used for treatment purposes  
 I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.  
 I authorize my insurance benefits to be paid directly to:  
**ChiroTime P.C., 11120 NE Halsey, Portland, OR 97220**  
 I authorize ChiroTime, P.C. to initiate a complaint to the insurance commissioner for any reason on my behalf.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Initials of Practitioner or Staff: \_\_\_\_\_

Complete the applicable section below:

**INSURANCE BILLING WAIVER**

I have elected to pay the Time of Service fee and have agreed to a specific payment plan. I understand that ChiroTime, will not bill my insurance. I will receive a monthly statement for my records, which I may use to submit to my insurance carrier if I choose.

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_

**Initials of Practitioner or Staff:** \_\_\_\_\_

---

**INSURANCE BILLING POLICY**

I, \_\_\_\_\_, a patient of ChiroTime, P.C., give ChiroTime, P.C. permission to submit a “clean claim” on my behalf for each service provided & to be re-imbursed directly by my health insurance provider for services provided. I acknowledge and agree that a part of my care may not be covered by my health insurance plan. I understand that only medically necessary care is reimbursed by my health plan. All services provided to me are subject to co-pays, deductibles, co-insurance and prior approval in some cases. I understand that my health insurance provider may not consider certain services medically necessary. I acknowledge and understand that I will be financially responsible for any non-covered part of my treatment. I agree to pay for these charges.

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_

**Initials of Practitioner or Staff:** \_\_\_\_\_