FLANERY
CHIROPRACTIC CLINIC

FLANERY CHIROPRACTIC FINANCIAL POLICY

PAYMENT INFORMATION

- Your insurance policy is a contract between you and your insurance company.
- We are a network provider for Blue Cross and Blue Shield only. If you have any other insurance carrier **we will file the claim for you, however it is your responsibility to pay for your visit in advance.**
- If we are not in-network with your insurance company, payment for your services must be made at time of service.
- All charges are your responsibility whether your insurance company pays or not. **Not all services are a covered benefit** in all contracts. Separate billing codes are submitted to your insurance for skeletal manipulation and the Active Release Technique®/ARPwave. For the first date of service, there is also an additional consultation fee submitted. _____**(initial)**
- **We require at least 4 hours notice if you are unable to be here for a scheduled appointment.** If we do not receive adequate notice, we reserve the right to charge a $50 missed appointment fee. _____**(initial)**
- Accounts become "Past Due" 60 days after your statement date. We reserve the right to send the account to a collection agency if the balance is not paid in full or if you have not made other payment arrangements, in a 90 day time frame.

I hereby acknowledge that I have read, understand and agree to the terms of this document relating to my insurance coverage and payment of my bill.

Print Name _____

_____

Patient's Signature
(Parent or Guardian's Signature)

Date_____

WELCOME TO FLANERY CHIROPRACTIC CLINIC

Patient Introduction Form

Name:_____ Date:_____

Name you prefer to be addressed as:_____

Home Address:_____

Home Phone:_____Work:_____Cell:_____

Email Address:_____

Birth date_____ Single_____Married_____Widowed_____

Social Security Number**(required)**_____ Male____Female_____

Patient Employer:_____Address:_____

Name of Spouse:_____Phone:_____

Emergency Contact Name:_____ Phone:_____

Is this due to an accident____ On the job?_____ Other_____ Date of Injury:_____

Please describe the circumstances:_____

_____

Prior Surgery:_____ Prior Accidents:_____

Current Medications:_____

Who may we thank for referring you to our office_____

Insured's Name (If not yourself) or Person Responsible for Payment_____

Relation: Birth date(required) SS#(required)_____

Address:_____Phone:_____

*****Our office will give you a courtesy text message reminder the day before your appointment, please provide the phone number that you would like to have on file:**_____

Signature:_____**Date:**_____

Flanery Chiropractic Clinic
4800 W 135th Street Suite 200
Leawood, KS 66224
(913) 232-7111

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I have received information about the proposed chiropractic treatment, any alternative courses of care, the benefits, the risks and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as with all health care, in the practice of chiropractic there are some very rare risks to treatment, including, but not limited to, muscle sprains and strains, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all risks and complications, I wish to rely on the doctor to exercise judgment during the course of the treatments which he feels at the time, based upon the facts then known, is in my best interests.

The doctor has responded to all of my requests for information about the proposed treatment. I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the described treatment procedure(s). I intend this consent to cover the entire course of treatment for my present condition.

(print patient's name)	(signature of patient)	(date)
(print guardian's name)	(signature of guardian)	(date)
(print witnesses name)	(signature of witness)	(date)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE **ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason: