Adjusted Health
CHIROPRACTIC

14989 S. DIXIE HWY, MONROE, MI 48161

www.adjustedhealthchiro.com (734) 244-4285

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only ONE goal. It is important that each patient understand both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This results in a lessening of the body's innate ability to express its maximum health potential.

ADJUSTMENT: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

We do NOT offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during your Chiropractic spinal exam, we discover a non-chiropractic unusual finding we will advise you to seek the opinion of the proper health care provider. OUR ONLY PRACTICE OBJECTIVE is to locate and correct vertebral subluxation, via the specific chiropractic adjustment, to allow the body to express its maximum health potential.

I _____ have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

*Signature ✕_____ Date _____

PAYMENT POLICY

In our office we accept the following types of payment:

CASH/CHECK/CREDIT CARD (Per visit): Payment due the day of service.

INSURANCE ASSIGNMENT: Co-pay and insurance reimbursement signed over to our office (as explained below)

It is our desire to assist our patients and make care as affordable as possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment of benefits will be discontinued once you have finished corrective care. We will notify you when this occurs.

NEXT PAGE

2. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are required to bring the payment into the office within THREE business days and sign it over to the office. Failure to do this will result in collection action.

3. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.

4. It will be your responsibility to supply this office with necessary forms to compete billing if needed. This clinic does not guarantee that insurance companies will pay. In the event that the insurance company disputes or rejects the claim, it will be the responsibility of the patient to pay all charges and pursue reimbursement from their insurance company. The insurance company has 30 days from the billing date to make a decision on a claim. Patient payment is expected on any fees over 30 days old.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

×_____ _____

* Patient Signature Date

EMERGENCY CONTACT

1st Contact Name: _____Phone #: _____

Relationship to Patient: _____ Alt Phone/email:_____

2nd Contact Name: _____Phone #: _____

Relationship to Patient: _____ Alt Phone/email:_____

Privacy Policy

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Adjusted Health Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review Adjusted Health Chiropractic's Notice of Privacy Practices prior to signing this document. Adjusted Health Chiropractic Notice of Privacy has been provided for me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health operations of Adjusted Health Chiropractic. The Notice of Privacy Practices for Adjusted Health Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Adjusted Health Chiropractic duties with respect to my protected health information.

Adjusted Health Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a reserved notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

*Patient Signature: ×_____ Date:_____