



FINANCIAL POLICIES:

Your insurance company will only pay for services that they determine to be “medically necessary.” As a patient you must understand that some or all services provided for your care might not be covered by your insurance benefits. You, as a patient, are liable for all charges that your plan does not cover. Our office will make every attempt to make you aware of charges prior to service and inform you of your insurance benefits. Before care is rendered, financial obligations and insurance benefits will be discussed and outlined. **If you use insurance, are a workers’ compensation patient, personal injury patient or Medicare/Medicaid patient then your 3rd party payer has 60 days to send us payment for services. If we do not receive the payment then you will be given 30 days to contact the 3rd party payer to discuss the outstanding claim. Then, after 90 days you will be responsible for covering the costs that the 3rd party payer will not cover. It is your responsibility to pay your co-pay as outlined in the agreement with your insurance company, or to pay for cash services after each visit.** If payment is not made at time of service, you will be billed. All appointments not cancelled within 24 hours will be charged a \$25 cancellation fee.

Patient’s Name: \_\_\_\_\_ (please print)

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

INFORMED CONSENT:

I understand and am informed that the professions of medicine, osteopathy, dentistry, chiropractic, physical therapy, nursing, optometry, pharmacy, podiatry, and others have known risks, which may include death, brain damage, paralysis, loss of organ function, or limb function.

I understand that as within the practices mentioned above, in the practice of chiropractic and spinal decompression therapy there are risks including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and failure to produce the results I seek.

I do not expect the doctor to be able to anticipate and explain all the risks and complications, as some may be unforeseen. I wish to rely upon the staff members of this clinic to exercise judgment during the course of the procedures administered to me based upon the facts then known to them, and to do their best to act in my self interest.

I am aware that I have the right to request information regarding other treatment options, which may include, but are not limited to, surgery, injections, medications, physical therapy, and manipulation.

I have read the information above, and I have had the opportunity to ask questions about its content. By signing below, I agree to continue with the treatment prescribed to be, or the person for who I am legally responsible for, by the Doctors and staff members of the Maplewood Wellness Center. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_