

# Lucas Chiropractic

## FINANCIAL CONSULTATION – PRIVACY STATEMENT– INFORMED CONSENT

- \_\_\_\_ (Pt. Initials) **OUR FEES:** All fees for services are based on the degree of complexity, the number of areas involved, and the time spent evaluating, treating, and instructing (do's & don'ts, exercises, etc.)  
Evaluation fees for new patients range from \$59.00 - \$286.00.  
Standard treatment fees range from \$42 - \$72.  
X-ray fees range from \$65 - \$115 for basic views of each spinal region.  
**Upon request, the doctor can give you an estimate of today's charges after reviewing your history and complaints.**
  
- \_\_\_\_ (Pt. Initials) **BILLING STATEMENTS:** Statements are generated the first Tuesday of the month and mailed out within 1-2 days. Balances over 90 days are past due and a 12% (annual) interest charge will be assessed. If required for recovery of past due accounts, you will be charged the collection and/or legal fees. A \$20 fee will be charged for returned checks.
  
- \_\_\_\_\_ (Pt initial) **GENERAL INSURANCE PAYMENT POLICY:** Your portion of the services (full amount, co-pay, deductible, etc.) Is due on the day of service. \_\_\_\_\_ Per your insurance plan, evaluation on this day may not be covered by insurance and will be your responsibility.
  - \_\_\_\_\_ (Pt initial) If your insurance covers chiropractic treatment, we will provide for your insurance company all necessary documentation, but we cannot accept responsibility for non-payment, late payment, or for negotiating a disputed claim. Your insurance policy is a contract between you and your carrier. **Even though we may have been given information by your insurance company regarding the benefits of your plan, this is not a guarantee of payment.**
  - \_\_\_\_\_ (Pt initial) **After 90 days, unpaid insurance claims will be converted to cash claims.**
  - \_\_\_\_\_ (Pt initials) We cannot reach the insurance company at this time (after hours, weekend, other). Until we can determine and discuss limitations on your plan, you will be responsible for payment on any excluded services.
  
- \_\_\_\_\_ (Patient initials) **PARTY OR WORK INJURY:** Bills will be submitted to the **PI or L&I** insurance carrier. I understand that if the claim is denied by the insurance, I will be responsible for payment.
  
- **FINANCIAL AGREEMENT:** If you are unable to pay your portion of the services on each visit, we ask that you commit to making payments on a regular schedule as agreed upon below until your account is paid in full.  
I will pay \_\_\_\_\_ down today and \_\_\_\_\_ each week / month. **(Minimum \$50 per month)** \_\_\_\_\_ (Pt initial)

By signing this document you are authorizing us to bill and receive insurance payments related to your treatment.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

## **PATIENT PRIVACY STATEMENT**

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

### **HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect. You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy. If you have any questions, concerns or complaints about the Notice or your medical information, please contact Yvette DeVore of our office at 509-525-4160. If you wish to file a complaint with the office of Department of Health and Human Services you may contact them at 2201 Sixth Ave, Seattle, WA 98121-1831 to the attention of the Immediate Office of the Secretary.

### **DISCLOSURE & CONSENT: CHIROPRACTIC ADJUSTMENTS AND CARE**

You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of muscle therapy, rehabilitation procedures, and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctors and therapists of this clinic.

I have had the opportunity to discuss my diagnosis, the nature and the purpose of the chiropractic adjustments and procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement from symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or had read to me, the above consent. I have also had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Patient Name (Signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Representative (Printed)

\_\_\_\_\_  
Patient Representative (Signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date