CHOICE CHIROPRACTIC & WELLNESS CENTER

3405 Penrose Pl., Suite 205, Boulder, CO 80301 (303) 442-2126 Fax (303) 444-0665
Dr. Jonathan D. Schnelle, D.C.

AUTHORIZATION, ASSIGNMENT and ACCEPTANCE AGREEMENT

In consideration of your undertaking to treat me, I agree to the following:

ACKNOWLEDGEMENT AND UNDERSTANDING

______ (Initials)

I hereby acknowledge that I am receiving (or about to receive) health care services at the office named above. As a patient of this office, I authorize Dr. Schnelle (and whomever he designates as his assistants) to administer such treatments as deemed necessary, and to perform the adjustment and any additional therapies as are considered necessary during treatment.

PRIVACY PRACTICES ACKNOWLEDGEMENT

______ (Initials)

I acknowledge that Choice Chiropractic observes specific practices to protect my identity and personal information. The specifics of these practices; rev June 2014, have been made available for my review.

PAYMENT AGREEMENT

Where no health insurance benefits are available, I agree to pay my account in full at the time services are rendered. If I have health insurance, I agree to file a request for coverage and full payment for services. If such request is denied, in whole or in part, after services have been rendered, I agree to pay my account in full upon my receipt of notice of such denial. The following stipulations also apply:

______ (Initials)

1. If I am financially unable to pay my account in full, Choice Chiropractic will consider agreeing to a payment plan that is comfortable for me and equitable for the office. Any such plan must be strictly adhered to. In the event that any payment under such plan is not made when due and Choice Chiropractic has not agreed to a change in the plan, then the full amount will immediately be due and payable.
2. A finance charge of 2% per month (24% a.p.r.) will be charged with a $10.00 minimum on all accounts over 30 days. This finance charge will be added to my bill on the 31st day after the account is due and every month thereafter.
3. If two consecutive payments under a payment plan are not made without prior consent by this office, my account will be turned over for collection, at the discretion of Choice Chiropractic. Should this occur, I agree to reimburse Choice Chiropractic for any attorney fees and court costs it incurs in collecting my bill.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

______ (Initials)

In consideration of the chiropractic services rendered and to be rendered, I authorize my attorney to make direct payment to Choice Chiropractic of any sum I now or hereafter owe Choice Chiropractic, from the proceeds of any settlement of my case. I also authorize any insurance company obligated to reimburse me for the charges of Choice Chiropractic to make direct payment to Choice Chiropractic.

ACCEPTANCE OF SERVICES

______ (Initials)

I understand that the frequency of treatment and the results obtained will, in large measure, depend upon the degree of my cooperation and following of orders from the doctor. I also understand that appointments will be made as scheduled and that **at least a 24-hour notice must be given to change/cancel an appointment. If I fail this, I agree to pay a $60 missed appointment fee.**

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OTHER MATTERS

_______ (Initials)

In the event any insurance company obligated by contractual agreement refuses to make payment to me or to you for the charges incurred for your services, I hereby assign to you full Power of Attorney; and transfer to you the cause of action that exists in my favor against any such company; and authorize you to prosecute said action in my name, your name or both as you see fit; and further authorize you to compromise, settle, or resolve, said claim as you see fit.

I have been advised that the doctor is willing to wait for payment for all or a portion of the bill for these services provided that, in the sole opinion of Choice Chiropractic, there continues to be a reasonable chance that payment will be made within a reasonable time, either by insurance proceeds or out of the settlement of a liability claim. I understand that the decision whether to wait for payment is solely that of Choice Chiropractic. If Choice Chiropractic elects to wait for payment, any amounts owed for services will accrue interest at the rate of 9% per annum, compounded annually.

I understand that payment for services rendered by Choice Chiropractic will be due on a current basis if: (1) it is determined that there is no insurance company obligated to pay for the services, or if the insurance company refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor; or (2) a liability claim exists and my attorney refuses to agree to protect the interest of Choice Chiropractic.

If I have a liability claim, but have not engaged the services of an attorney, then payment for the services rendered by Choice Chiropractic will be made on a current basis and my bill paid in full as soon as my liability claim is settled.

I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I understand that a finance charge of 2% per month (24% a.p.r.) will be charged with a $10.00 minimum on all amounts not paid within 30 days of the date due under this agreement. This finance charge will be added to my bill on the 31st day after the bill is due and each month thereafter.

AUTHORIZATION TO RELEASE INFORMATION

_______ (Initials)

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

I certify that I have read and understand the above authorization for treatment, the reasons why treatment is necessary and that any risks regarding chiropractic treatment will be explained to me upon my request.

Date: ___________________.

Patient's Signature: ____

Or Guardian's Signature: ____