



Patient Policy

Appointment Policy

In order to achieve maximum results and optimal wellness, patients must be dedicated to their chiropractic treatment plan given by the doctor. Therefore, we ask that you make your chiropractic appointments a priority in your busy schedule. If for any reason you cannot make your scheduled appointment we ask that you give this office 24 hour notice of cancellation.

Payment Policy

We request that 100% of the office visit or co-pay be paid at time of service. For your convenience we accept MasterCard, Visa, cash or checks.

Insurance Policy

We work with several insurance companies in order to serve you better. Office co-pays are due at time of service. It is to be understood and agreed that any charges not covered by insurance will be billed to you directly and you are personally responsible for payment of these services. If you have health coverage under Medicare, please speak with the staff to obtain the appropriate paperwork.

Consent to Chiropractic Treatment

As there are inherent risks with any medical procedures, health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. While rare, some patients have experienced rib fractures, muscle and ligament sprains or strains, or disc injuries following chiropractic adjustments. There have also been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke or neurological impairment. The possibility of such injuries resulting from chiropractic treatment is extremely rare. By signing this form, I am consenting to chiropractic treatment and acknowledge the associated risks of such care.

Termination of Care

Because we care about your health here at Desired Health Chiropractic, we ask that if you decide to end care at our clinic that you notify us so we can complete your file. If at any time you decide to re-enter into our care we will be here for you.

Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Desired Health Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Prior to signing this consent, I can request The Notice of Privacy Practices for Desired Health Chiropractic which describes such uses and disclosures more completely. With this consent, Desired Health Chiropractic may call and leave messages, mail, or e-mail my home, or other alternative location in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. By signing this form, I am consenting to allow Desired Health Chiropractic to use and disclose my PHI to carry out TPO.

I have read and agree to the above patient policy. I have been given the opportunity to ask additional questions about this policy and am looking forward to starting my road to recovery.

Patient name (print) _____

Patient signature _____ Date _____