GRASS LAKE CHIROPRACTIC CENTER

139 W MICHIGAN AVE. PO BOX 141 GRASS LAKE , MI 49240
Phone: 517 522 8315 Fax: 517 522 5493

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 attain it. This will prevent any confusion or disappointment.

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 of the spine.

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 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter a non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

PAYMENT POLICY

There are two forms of payment:

Cash – Every time you come in. After 60 days of non-payment, a $25.00 late fee will be added to your account to be compounded monthly.

OR

Insurance assignment – Co-pay, insurance reimbursement signed over to our clinic (as explained below).

INSURANCE ASSIGNMENT PROGRAM

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

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a supportive health care program is recommended. We will notify you of the change.
2. All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made.
3. The insurance carriers are billed on specific 15-30 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action.
5. 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.
6. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old.

I, ____e have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

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

____ ________________

Patient's Signature Date

Consent for Purpose of Treatment, Payment, and Healthcare Operations

I acknowledge that Grass Lake Chiropractic Center's "Notice of Privacy Practices" has been provided to me. I understand I have a right to review Grass Lake Chiropractic Center's "Notice of Privacy Practices" prior to signing this document. Grass Lake Chiropractic Center's "Notice of Privacy Practices" has been provided to 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 care operations of Grass Lake Chiropractic Center. The "Notice of Privacy Practices" for Grass Lake Chiropractic Center is also provided on request at the main administration desk of this practice. This "Notice of Privacy Practices" also describes my rights and Grass Lake Chiropractic Center's duties with respect to my protected health information.

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

____ ________________

Signature of patient or personal representative Date

____

Printed name of patient or personal representative

____

Description of personal representative's authority

____

Name of person(s) authorized to gain access to account information

Emergency Contact Sheet

1st Contact: ____

Address: ____

____

Phone: ____

2nd Contact: ____

Address: ____

____

Phone: ____