MISSED APPOINTMENTS

A $30 charge may be applied for missed appointments and for appointments that have been canceled without a 24 hour advance notice.

Patients missing massage appointments or canceling massage appointments without 24 hour advance notice will be charged at the full price of the massage.

RETURNED CHECKS & COLLECTIONS

A minimum of $10 will be charged for all returned checks. You will be responsible for any bank charges exceeding this amount.

We reserve the right to forward any balance past due by 90 days or more to a third party for collection purposes.

INSURANCE

We will bill your insurance as a courtesy. However, we are not responsible for your insurance company's action or inaction in paying for the service.

We will assume your insurance company will process and pay your claim within 30-45 days, as it is the law.

Your bill is your responsibility if, for any reason, your insurance company does not pay.

A current insurance card must be provided and if eligibility cannot be verified at the time of service, payment in full will be expected. It is also your responsibility to notify us of any changes.

Not all services are covered by all insurances. Please review your insurance so that you are aware of your individual coverage plan and limitations.

PAYMENT

Co-pays, co-insurances, and all deductible payments are due at the time of service.

All checks should be made out to
Dr. Watson or Watson Chiropractic.

Patients without insurance are expected to pay in full at the time of service unless other arrangements have been made with the billing department.

We accept
- Cash
- Local checks
- CareCredit
- Debit cards (that have a Visa or Mastercard logo)
- Visa or Mastercard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the Doctor to treat my condition as he deems appropriate. It is understood and agreed that I am responsible for all bills incurred at this office.

Patient's Initials: __________

continued

I have read and received, if requested, a copy of these notices and understand my rights contained in this notice. I acknowledge that I can obtain a copy of the Privacy Notices at any time. By way of my signature, I provide Watson Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations. I acknowledge and understand the office policies and procedures explained above, including insurance procedures. I hereby authorize my insurance company to pay Dr. Watson directly. The copy of this authorization can be considered an original for insurance purposes.

Patient's Initials: ___________

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the 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 upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures.

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's Signature: ____

Name: ______________________________________ **Date:** ______________

Responsible party (if applicable)

Name: ______________________________ Relationship to patient: ______________________

Signature: ____

☐ I choose to decline receipt of my clinical summary after every visit (diagnoses, patient info, etc.)