Media District Chiropractic 2811 W. Olive Ave. Burbank, CA 91505

Dear Patient:

Our office policy has been established to assure that the best health service can be provided to you and your family.

Examinations in this office are to evaluate your complaint. They are not to be considered a complete physical examination. For general health purposes, we advise you to see your personal physician. Chiropractic manipulative therapy and Acupuncture, as practiced in this office, is a safe, conservative therapy. As with any medical procedure, there is the possibility of risk to the patient. When, in the opinion of your doctor, there is risk to you from the treatment outlined, that risk will be discussed before treatment has begun. Accepting you as a patient does not guarantee relief or cure. We encourage you to ask your doctor any questions regarding your condition and treatment. In order to receive maximum benefit from your treatment, you are encouraged to maintain your prescribed treatment schedule.

Fees are due and payable when services are rendered. You may pay by check, cash, debit card or credit card. We offer a cash discount to patients who pay at the time of service or pre-pay for a chiropractic treatment plan. Patients on a once a month plan or maintenance must pay at the time of each visit or the beginning of each month. No discount will be given to patients we must bill. Should a payment schedule be necessary, arrangements must be made with the Business Office prior to any treatment. This will avoid any misunderstanding and enable you to keep your account in good standing. All accounts over 60 days old will be subject to a monthly billing charge. There is an office handling charge, plus bank fees on all returned checks and the check will not be re-submitted. You will be required to pay by one of the other methods described above.

Patients with Third Party Benefits: Please be aware that if you have health insurance, or other source of coverage, the doctor's services are rendered to you and not the insurance company. We bill your insurance company as a courtesy to you. We will not provide services on the assumption that the charges will be paid by the insurance company. You will be required to pay all fees until your benefits can be verified by this office. If you are insured by a Managed Care Organization that we are contracted with, you are responsible for all deductibles, co-pays, patient portions and any services which are not covered by your plan at the time of service. It is your responsibility to provide this office with current insurance information and a completed claim form when required. Without this information or on a disputed claim, you will be responsible for payment of any and all care. If you are insured with a non-contracted insurance carrier or have a third party claim, each visit we expect an estimated partial payment or may request a credit card authorization on file and you remain fully responsible for all services. We do not accept responsibility for collecting your claim or for negotiating a settlement. Monthly installments must be paid on disputed services until your insurance carrier has resolved your claim, unless there is a valid lien on file.

Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure. You have the option to opt out of this at any time.

For cancellation of appointments, we require that 24 hours' notice is given. Should you miss a scheduled appointment, you NOT your insurance company, are responsible to pay a missed appointment fee. Patients late 15 minutes or more will be asked to reschedule for the next available appointment.

I, the undersigned, agree to be solely responsible for payment of all services rendered to myself and/or any member of my family, and should any claim for same be referred for collection, the undersigned further agrees to pay all costs of collection, including reasonable attorneys' fees, plus interest at 10% annum from date of first delinquency. I certify that I have read and completely understand the office policy set forth by this office, and I agree to its stipulations. I also acknowledge receipt of the Notice of Privacy Practices. My signature below is my consent to be examined and treated in this office.

_____	_____	_____
Signature (Patient/Parent/Guardian)	Date	Witness