7570 W 21st St N Ste 1006A Wichita KS 67205
1445 N Rock Rd Ste 130 Wichita KS 67206
P: (316) 337-5757 F: (316) 337-5758

Written Financial Policy

Thank you for choosing Elite Sports Chiropractic LLC. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Most Insurance Accepted
- Cash, Check, Visa®, MasterCard® or Discover Card®

Please note:

-Elite Sports Chiropractic LLC requires payment of co-pays or self-pay prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received (refunds pertain to Care Credit purchases).

-We accept payment in thirds. For plans requiring multiple appointments, alternative payment arrangements may be provided.

-For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

-A fee of is charged for patients who miss or cancel more than 4 times in a calendar year without 24 hour notice.

-Elite Sports Chiropractic LLC charges for returned checks.

-If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within , you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

-I understand that as with all health care that there are some associated risks with treatment. Occasionally patients may have some increased discomfort after treatment. If that happens, I will apply ice to the areas as instructed and call the office or emergency room if I am concerned.
-If any tests are performed I understand that the doctor will notify me of the results as soon as possible. I consent to the performance of chiropractic adjustments, physiotherapy, x-ray and other standard chiropractic procedures and therapy on me by any of the staff or doctors at Elite Sports Chiropractic LLC.
-I understand that there are risks to treatment, though very rare, may include but are not limited to strains/sprains, disc herniation, fracture and stroke. However, a recent study over 10 years determined that you are No more likely to suffer a stroke in a chiropractic office then in a medical office.
-I do not expect the doctor to be able to anticipate and explain all risks and complications that can arise and I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time based on the facts known, is in my best interest.

Authorization to treat a minor

I warrant that I am the legal guardian of the above named child and hereby authorize Elite Sports Chiropractic LLC to examine and treat this child. This authorization is to cover and Elite Sports Chiropractic LLC staff member and any future exams and treatment for this child. I will notify Elite Sports Chiropractic LLC should my guardian status change and will notify Elite Sports Chiropractic LLC if I require further authorization.

Acknowledgement of Privacy Notice

I hereby acknowledge that I have read the Notice of Privacy Practices. I understand that if I have questions or complaints regarding my rights, that I may contact Elite Sports Chiropractic LLC. I acknowledge I have the right to request a copy of the notice for my records. I further understand that Elite Sports Chiropractic LLC will offer the updates to this privacy notice should it be amended, modified or changed at any time.

Patient Signature Date

Print Name _____