Pow-HER Chiropractic 600 Jefferson Plaza Suite 350 www.powherchiro.com
Dr. Cheryl Lee-Pow Rockville MD 20852 301-279-9009

PATIENT CONSENT AND FINANCIAL POLICIES

CONSENT FOR EXAMINATION & TREATMENT: I voluntarily consent to receive chiropractic/medical treatment and diagnostic testing at Pow-HER Chiropractic. I know that I am responsible for all charges incurred at this facility. If I have no insurance benefits, payment is due at the time of service. My balance owed to this office will not exceed $50.00 unless I am placed on an authorized payment plan.

INSURANCE ASSIGNMENT OF BENEFITS: In order to receive the best care possible within your benefits, it is important that you comply with our financial policy: I assign payment by my insurance company directly to Pow-HER Chiropractic. If my current policy prohibits direct payment to this office, I instruct my insurance company to make the check out to me and mail it to Pow-HER Chiropractic.

Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney' s fees if your account is turned over for collection. If your insurance company sends you checks, it is your responsibility to deliver them to our office. I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents.

Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment unless I am placed on an authorized payment plan. It is illegal to waive these fees. I understand that I am financially responsible for charges and co-payments not covered by my insurance carrier. In automobile cases, I will bring my Personal Injury Protection forms (from my automobile insurance carrier), no matter who caused the accident, to this office within four (4) weeks or I am personally responsible for my bill.

If my insurance carrier has not paid a claim within sixty (60) days of submission, I agree to take an active part in the recovery of my claim. If my insurance carrier has not paid a claim within ninety (90) days, I am responsible for the balance owed.

When my schedule of visits is one time per month or less, I am aware that this office will no longer accept insurance assignment. Pow-HER Chiropractic will provide me with an insurance form if I request it.

In the unfortunate event collection procedures are required to collect an outstanding account balance, the patient shall be responsible for all reasonable cost of a collection agency, attorney, and / or court costs.

RELEASE OF INFORMATI0N: I authorize the use and disclosure of health information that pertains to me for treatment, payment, or official operations. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. In addition I authorize Pow-HER Chiropractic to share findings/send reports to my family physician or other health care provider listed on my health history form.

I understand that I may revoke this authorization at any time by signing the revocation of my copy of this form and returning it to Pow-HER Chiropractic. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand this authorization will automatically expire at the end of my treatment cycle. I understand that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that Pow-HER Chiropractic will receive compensation for the uses and disclosures that I have authorized.

I authorize Pow-HER Chiropractic to leave any message necessary at my home/work in regards to any appointments, billing or insurance issues that may accrue.

I authorize Pow-HER Chiropractic to allow my spouse or anyone listed below to schedule or cancel an appointment on my behalf.

_____ _____ _____

Patient's or Patient's Guardian's Name (Signature) Patient's or Patient's Guardian's Name (Please Print)