Saleeby Chiropractic Centre, P.A.

Stephen M. Saleeby, D.C.
Wayne J. Prickett, D.C.

Consent Form

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 obtain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces 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 its 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 a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of another health care provider.

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.

I, ______________________________ have read and fully understand the above statements.
(print name)
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.

____ _______________________________________
(Signature) **(Date)**

****Pregnancy Release:**
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual period: _______________________

____ _______________________________________
(Signature) **(Date)**

****Consent to evaluate and adjust a minor child:**
I, _______________________________ being the patient or legal guardian of _________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ _______________________________________
(Signature) **(Date)**

3814 Browning Place, Suite 102, Raleigh, North Carolina 27609
919-782-4733 Fax 919-783-8225

Financial Policy

Thank you for choosing us as your chiropractic provider. We are committed to providing you the best possible care, and we are pleased to discuss our professional fees with you at any time. The following is a statement of our Financial Policy which we require you to read and sign prior to any medical services.

- FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. NO EXCEPTIONS. IF YOU DO NOT HAVE YOUR CO-PAYMENT, YOU WIL NEED TO RESCHEDULE AND YOU WILL BE ASSESSED A $50.00 CANCELLATION FEE.
- ALL PAYMENTS WILL CE COLLECTED UPON CHECKING IN FOR YOUR SCHEDULE APPOINTMENT.
- WE ACCEPT CASH, PERSONAL CHECKS, CREDIT CARDS, and CARE CREDIT.

INSURANCE

- If we are a participating provider with your insurance plan you are responsible for all co-payments, deductibles and any non-covered services at the time of service. Deductibles and an estimated co-insurance must be taken care of prior to service. As a courtesy we will file insurance claims with most insurance carriers, provided you have supplied us with the proper information.
- If we are NOT a participating provider with your insurance plan you are responsible for full payment at time of service. If you need to file your own insurance our office will provide you with the proper documentation.

MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patients' account regardless of who the insurance policy holder is. For unaccompanied minors non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment of the account period.

WORKMAN'S COMPENSATION

All workmen's compensation claims must be verified in writing by the employer. Verbal or telephone verifications are not acceptable. If you have seen another physical for the same compliant and authorization for a change of physical must be verified on your company's form.

PERSONAL INJURY WITH ATTORNEY

If you are being represented by an attorney or a third party payer, we will provide you with the proper information to file your claim. You are responsible for full payment to our office at the time services are rendered.

AUTOMOBILE ACCIDENT

If you were in an automobile accident and you have "Med-Pay" automobile insurance our office will provide you with the proper documentation to file the claims. It will be your responsibility to file the claims. If you have health insurance we will file a claim for all professional services received.

MISSED APPOINTMENTS

Failure to give 24 hour notice of cancellation of your appointment will result in a $50.00 fee billed directly to you. We will not bill your insurance company for this amount. You will be responsible for prompt payment of this fee prior to being seen at your next scheduled visit.

FORMS

We will be happy to complete any medical forms. Payment of $10.00 is required prior to completion of each form(s). Please allow 7-10 business days for your form to be completed.

COLLECTIONS

If your account balance becomes past due and is sent to an outside collection agency, you will be responsible for any additional fees incurred. This will occur if balances are more than 90 days past due.
All monthly statements are due and payable in full upon receipt.
All returned checks are subject to a $25.00 service fee.

Thank you for understanding the necessity of our financial policy. If you need to make special payment arrangements please bring this to our attention prior to being examined. Please sign your name with the date below to indicate your understanding of our policy and your willingness to abide by it.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I agree to pay my estimated co-pay at the time services are rendered, including my deductibles, and further understand that the estimated co-pay is neither a guarantee of payment by insurance company, nor necessarily an accurate reflection of my actual co-pay as determined by my insurance company upon processing my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time upon request of this office, I will immediately pay the balance on my account. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney(s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information I have provided is true and complete, to the best of my knowledge.

Patient's Signature:______________________________________ Date:________/________/________

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INSURANCE POLICY

Saleeby Chiropractic Centre, P.A. will file insurance claims to a third party on your behalf as a courtesy. Many patients do not verify their insurance benefits prior to coming to our office. Therefore, our staff will attempt to gather as much information from your insurance company regarding your coverage during your initial visit. Although this can be very time consuming, we are happy to provide this service for you.

Please understand that we provide these services for your convenience, and ultimately the arrangement you have with your insurance carrier is contractual between you and the carrier. Our knowledgeable staff will assist you in every way possible to ease this burden from you. Worker's Compensation claims and Personal Injury claims (automobile accidents) will be handled separately.

OUT OF NETWORK

Our office does not participate in several networks due to the restraints that are placed on our ability to provide the best care possible to our patients. We have adapted our fee schedule to accommodate patients that may have out of network benefits or no benefits at all. This policy has worked very well for most patients. Our goal is to provide you with the best care available. Please feel free to discuss options you may have with one of our financial staff members.

I, ____ have read the above statement and understand that as a courtesy to me, the staff at Saleeby Chiropractic Centre, P.A. will attempt to verify my insurance information and share that information with me prior to my leaving today. I also understand that ultimately the contract is between my insurance company and me.

____

Patient Signature Date

____

Witness Signature Date

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Broken Appointment Policy

It is the policy of this office to charge a $50.00 fee for appointments which are not canceled 24 hours prior to their scheduled time.

After Hours Weekend Visit Policy

There will be an additional charge of $27.00 for after hours and weekend appointments.

I, the undersigned, have read and understand the above stated policy.

____

Signature Print Name Date

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