Buckner Chiropractic Center, Inc

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Women's Health Issues
- ☑ Wellness Topics
- ❑ Diet and Nutrition
- ❑ Exercise and Fitness
- ❑ Stress Management

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	

Buckner Chiropractic Center, Inc

NO SHOW POLICY

This is to inform you that Buckner Chiropractic Center has a NO SHOW POLICY which states that if you do not cancel an appointment 24 hours prior to the time of the appointment, you will be charged $45.00 for the missed appointment. Your insurance will not pay this charge and it will be your responsibility. The exceptions to this policy include family emergencies such as a death in the family or severe family illness or accident, unexpected trip out of town or vehicle break down.

I understand that this charge is due upon receipt of monthly statement or next scheduled appointment.

Please Type your Full Name as agreement to this policy **Date**

Buckner Chiropractic Center, Inc

Payment Agreement/Responsible Party Policy

I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of service. I understand that a fee is charged for all visits, examinations, or medical reports. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate him for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further express agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Buckner Chiropractic & Rehabilitation Services all benefits. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility. Full payment is due at the time of service except if otherwise arranged or mandated by law.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances.

Unpaid charges over 60 days will incur a monthly service fee of $25. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill. I understand and agree that some additional charges may come through from my treatments that are not included in the initial estimated bill.

I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

1. Providing Buckner Chiropractic & Rehabilitation Services with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.

2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit.

I give my consent to Buckner Chiropractic & Rehabilitation Services to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I have read and agree to the terms outlined above: **Please Type Name for Signature**

Signed: (patient or guarantor)_____ Date: _____

For: (print patient name) _____

Buckner Chiropractic Center, Inc

Terms of Acceptance for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both patient and doctor to be working towards the same objective.

Buckner Chiropractic and Rehabilitation Services has only one goal: to return sick people to full health and to achieve a better quality of life by helping them obtain and maintain health and wellness naturally. Our method is specific adjustment of the spine and extremities (e.g.: ankles, elbows, jaws, knees, shoulders, wrists).

It is importation that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Initial Intensive Care

This includes relief care and initial spinal adjustment. The goal is to eliminate or reduce your major complaint, as well as stabilize your body. This requires frequent visits (several times per week) that may continue for weeks or months. Your health insurance may cover this portion of care, since this is dealing with a symptomatic problem.

Rehabilitative Care

This rehabilitative care is designed to provide optimum healing of the function of the spine, associated tissues and organ systems. This helps prevent the original problem from returning. Frequency of visits varies but it is less than Initial Intensive Care.

Wellness/Maintenance Care

This is designed to maintain your improved health and spinal function. The decision to begin this care is made once it is determined your spine has recovered as best it can from the possible permanent damage that may have occurred prior to care. Visit frequency is based on the needs of the individual and is less than Rehabilitative Care.

We do not offer to diagnose or treat any disease or condition other than spinal adjustment. However, if, during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

All of these options will be explained at your report of findings. Then you will be able to begin a course of care that best fits your health goals.

Questions

Do not hesitate to ask questions; we want you to be informed. Just as in a good marriage, proper communications is an absolute necessity. Our primary concern is to help you attain your optimum health.

Acknowledgment

I have read and fully understand the above statements. 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.

Please Type Name for Signature

Patient's Name (Print) _____

Patient's Signature (Parent, if minor) _____

Relationship to Patient _____ Date _____

Buckner Chiropractic Center, Inc

Notice Of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Please Type Name for Signature

Patient's Name (Print)

Patient's Signature (Parent, if minor)

Relationship to Patient . Date

Submit