Dear Patient,

Cancellation/ No-show policy:

Please be advised that in the event that you are unable to make your appointment and do not give a 24 hour notice, you may be liable for a $35 cancelation/no-show charge. We understand that emergencies happen and will handle each situation as it arises. If you cancel the same day, you will be charged a $35 late cancellation fee.

Late arrival policy:

Please be aware that we understand things beyond your control can occasionally prevent you from making it to your appointment on time. We typically try to allow a 10 minute grace period, but please understand that the daily schedule may not always allow for that and we apologize if the office is unable to see you. We respect your time and attempt to try our best to always be on time. Late arrivals can create a back up for other patients that may be scheduled after you. We do understand that we ourselves occasionally run behind, so we try our hardest to be as understanding and accommodating as possible. We will not charge for a late arrival, even if it is decided that we cannot see you.

Thank you for your understanding.

X_____ Date_____

Please circle:

Have you been to another Chiropractor within the past 12 months? **Y / N**

***Failure to notify us of these visits can result in claims being denied and becoming an out of pocket expense to you.**

PLEASE NOTE- MEDICARE/MEDICAID/UN-INSURED PATIENTS:

Medicare and Medicaid insurance plans will not cover a Chiropractic office visit, they will only cover adjustments. Please be advised that if an office visit is rendered, you will be responsible for the charge. The initial office visit (uninsured patients as well) will be $200, and other office visits rendered after that visit will range from $80-$120 dependent on complexity. ****INITIAL_____**

To our patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card to put on file to pay your bill. This is an advantage for both you and the company that makes check out easier, faster and more efficient. Chiro-Med & Rehab has implemented a similar policy.

With the rising cost of healthcare and reductions in reimbursement, we are forced to make policy changes to ensure that we are able to continue to provide high quality healthcare to our patients. We will now kindly ask you (or the guardian if a minor) for credit card information to be held securely for payment processing once your insurance has determined the amount that you are responsible for. At that time, we will notify you of the amount and the card will be charged for that balance 5 days from that notification. At that time, if you wish to pay via check or cash, you can come to the office and do so within the 5 days. If payment is not received, the card on file will be charged. Understanding balances can run high due to deductibles, if a payment arrangement is needed, one can be set up at the time of notification. A copy of the receipt will be sent to you once processed.

This will be an advantage to you as you will no longer need to mail a check. It simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork, reduces postage in a digital era and ultimately helps lower the cost of healthcare. Co-pays due at the time of visit will still be due at that time.

Keeping a card on file does not eliminate your ability to dispute any charges. Please contact the office if there are any questions regarding your account. Your card will be stored in our secure payment system. It will require your demographic information which will include an email address, and your credit card information. The credit card information, once stored, will be truncated and will only show the last 4 digits. You will be asked to provide the card details to be entered and complete the section below for authorization. *No show/ late cancellation ($35) fees will be automatically charged on that day.

Sincerely yours,
Chiro-Med & Rehab

●●

By signing below, I authorize Chiro-Med & Rehab to keep my signature and my credit card information securely on-file in my account. I authorize Chiro-Med & Rehab to charge my credit card for any outstanding balances when due 5 days after notification, unless other arrangements are made.

Name:____________________________________

CC #:____

EXP: __________ / 3 DIGIT CODE: __________ / ZIP CODE: __________

Email address:____

Signature:____ Date:__________

Southwestern Vermont Health Care

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____ MR#: _____
Print

Address: _____
Print

I hereby authorize SVHC the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. This authorization is valid for 1 year unless otherwise specified.

Name and Address of Persons/Organizations authorized to receive information:
Chiro-Med & Rehab- 345 Elm Street, Bennington, VT 05201; P: 802-753-7930; F: 802-753-7924

Specific description of information that may be used/disclosed and dates of service:
- ☐ X-ray Films and Report
- ☐ Office Notes
- ☐ ER Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Outpatient Department
- ☐ Other: (Describe) _____

This authorization permits SVHC to disclose my protected health information from my health record with no limitations placed on history of illness, diagnostic or therapeutic information including any treatment for alcohol and drug abuse, psychiatric impairment, HIV/AIDS related illnesses or genetic testing.

The information will be used / disclosed for the following purpose(s):
- ☐ Requested by the patient and for the patient (not necessary to disclose purpose).
- ☐ Insurance claim
- ☐ Other: (Describe) _____

- ☐ I understand that this authorization is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to ensure healthcare treatment.
- ☐ I understand that I may inspect or copy the information used or disclosed.
- ☐ I understand that I may revoke this authorization at any time by notifying SVHC, in writing, except to the extent that:
  1. action has been taken in reliance on this authorization; or
  2. if this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

_____ _____
Signature of Patient or Patient representative Date:

_____
Relationship to patient or representative's authority to act for the patient (if applicable).

Request Received:_____ Date Processed: _____
Date: Date:

☐ Copy of Authorization given to the individual

Initial of person finalizing request: _____
Created date: 4/14/03 Revised date: 5/5/03

100 Hospital Drive
Bennington, VT 05201

Phone: (802) 447-5323
Fax: (802) 447-5138

Chiro-Med & Rehab
345 Elm Street, Bennington, VT 05201
P: 802-753-7930; F: 802-753-7924

I, _____, DOB _____
authorize the disclosure of specified information as described below, for continuation of treatment to Chiro-Med & Rehab

Information to be released:

_____

_____

_____

_____

Method of release: MAIL / FAX / EMAIL / PHONE

This authorization shall remain in effect from the date of signature until:

__ Specific expiration date _____

__ NO EXPIRATION DATE

Signature _____ Date _____