

Dr. Stuart Johnson

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Please READ AND INITIAL the following:	
Acknowledgement of Receipt of Notice of Privacy Practices Health Information. Notice of Privacy Practices is available at t	s: I have read/acknowledged the Notice of Privacy Practices for Protected the front desk upon request.
	Initials
office that payment be made at the time of service for all service these visits will be considered self-pay. If care is ceased, any remaining balance.	for all charges incurred at Sturgis Chiropractic, P.C. It is the policy of this ces rendered. If the incorrect insurance is provided at the time of service, emaining balance must be paid in full. The credit/debit card on file will be wellness/corrective care, the visits will not be submitted to insurance and
responsible for the payment of any covered or non-covered servinese visits will be considered self-pay.	I may have is an agreement between the carrier and me and that I am vices I receive. If the incorrect insurance is provided at the time of service, nance/wellness/corrective care, the visits will not be submitted to fees.
	Initials
Signature of Patient or Parent/Guardian	Date
INFORMED	CONSENT TO TREAT
physiotherapy, shockwave treatment, diagnostic x-rays, massa below, for whom I am legally responsible) by the Sturgis Chiro	res, including chiropractic adjustments, examinations, various modes of age therapy, and any supportive therapies on me (or on the patient named practic and /or other licensed providers and support staff who now or in with or serving as back-up providers, including those working at the clinic
I will discuss with the Sturgis Chiropractic provider and/or with if I choose to do so.	other office or clinic personnel the nature and purpose of the procedures,
am informed that, as is with all healthcare treatments, there a for short periods of time, aggravating and/or temporary increase strokes, dislocation and sprains. I do not expect the Sturgis	of guaranteed and there is no promise to cure. I further understand and lare some risks to treatment, including, but not limited to, muscle spasms in symptoms, lack of improvement of symptoms, fractures, disc injuries, Chiropractic provider to be able to anticipate and explain all risks and evider to exercise judgment during the procedure which the doctor/health yn, is in my best interests.
and there is no promise to cure. Accordingly, I understand that I further understand that there are treatment options available	alth. However, like all other health modalities, results are not guaranteed tall payment(s) for treatment(s) are final, and no refunds will be issued. for my condition, these treatment options include, but not limited to selfedical care. I understand I have the right to a second opinion and secure oms and treatment options.
	ask the doctor/health care provider questions about its consent if I have dures. I consent to cover the entire course of treatment for my present ment.
Name of Patient:	
Signature of Patient:	

Name Printed of Guardian/Parental and Relationship to Patient:

Guardian/Parental Signature: _____

Date: _____

INSURANCE ABN Advanced Beneficiary Notice

Deductible needs to be met before services are covered.

To use insurance, you must have a neuromusculoskeletal injury or problem.

Insurance companies will say you have so many visits a year, but unless it is for an injury, our contract with the insurance company states: "Services to be billed must be medically necessary."

*Insurance only covers visits that are medically necessary, no maintenance/wellness or corrective care.

*Insurance pays for one chiropractic visit a day when covered.

*Covered visits must be in a treatment plan with a current diagnosis and visits must be used within a certain time frame.

*Treatment plan must be reasonable within healthcare guidelines showing progress.

*It is fraudulent to continue billing insurance once treatment plan is finished.

*Progress exams are a required part of treatment plan and not covered by insurance.

*The Gonstead Chiropractor seeks the cause of dis-ease through the use of x-ray analysis to deliver a specific adjustment.

Non-Covered Charges:

PROGRESS EXAM \$40
SELF-PAY REHAB \$20
EXTREMITY ADJUSTMENT \$15
ELEC STIM \$20
SHOCKWAVE \$60
CERVICAL X-RAYS \$100
THORACIC X-RAYS \$120
LUMBAR X-RAYS \$120
FULL SPINE X-RAYS \$160
MASSAGE THERAPY \$45-\$115

SIGNATURE	DATE