DR. RICHARD DE CARLO

DOCTOR OF CHIROPRACTIC

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Office Policies for treatment, payment, and appointments

Initial Patient Name:

_____ I authorize De Carlo Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process a claim for reimbursement of charges incurred by me as a result of any consequences thereof.

_____ I hereby authorize and direct payment of any medical expense benefits allowable to Dr. De Carlo as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee.

_____ I fully understand and agree that insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for any expenses not paid for by the insurance. Should I default, I agree to pay all cost of collection, including collection agency fees, court costs, and attorney fees.

_____ I acknowledge that Dr. De Carlo requires X-rays to be taken so a complete study and analysis may be made of my present problem or illness. I authorize and consent to Dr. De Carlo completing a radiographic examination and to administer whatever treatment is deemed necessary in order to treat my present problem or illness.

_____ To the best of my knowledge, I am NOT pregnant and Dr. De Carlo had my permission to X-ray me for diagnostic interpretation.

_____ Our office requires 24hour notice for cancellation of all appointments. If 24hour notice is not given, the patient will be charged a fee of $25 for the missed Chiropractic appointment and an $80 fee for the missed massage appointment. The patient is solely responsible as this can not be charged to insurance companies. We do understand emergencies arise and those cases will be under the discretion of our staff.

_____ It is the policy of this office to abide by any and all HIPPA requirements, protecting all of your personal information. If you would like a copy of this policy at any time, please ask our staff and one will be provided immediately.

_____ I agree that a photo static copy of this original shall serve as an original should verification be needed.

By initialing and signing this form, I certify that I, _____ have read, understood, and agree to abide by all of the above statements.

Patient Signature:_____ Date:_____

Witnessed By:_____ Date:_____

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