CHIROPRACTIC
LIFESTYLE CENTER

Financial Policies

It is our financial policy that all co-pays, uninsurable visits, and retail items are paid in full at the time of service. We accept Visa, Mastercard, Discover, American Express, cash and personal checks. We offer a **15% military discount on chiropractic services** for active duty members and their immediate family (**must show military ID**). If your primary insurance policy covers services provided by CLC, we are happy to bill them for you. ***However, please know that your plan is a relationship between you and your insurance company. The ultimate responsibility for payment of services is with you. Any amount not covered by your plan, including annual deductible, is your responsibility.*** Unpaid balances will have interest added to them (1% per month) after 90 days. Returned check fee is $20.00.

If you are being treated for an accident or a work-related injury, we will bill appropriate carriers for you once we have received all necessary billing information. In the case of a third party claim, we may file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010. I, the undersigned, understand and acknowledge that in the event a medical lien is filed, and that if the lien is paid or settled, I will be provided with a written Satisfaction of Lien and I am responsible for filing the Satisfaction of Lien with the County Auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien. All 3rd party lien cases require legal representation and will have interest added to them at the rate of 1% per month (12% APR), beginning 90 days after the release from treatment.

Missed Appointments: We charge $50.00 for all missed chiropractic appointments. Missed massage and acupuncture appointments will be charged at the full amount ($50 for massage). **PLEASE CALL 24 HOURS PRIOR TO YOUR APPOINTMENT if you cannot make your scheduled time in order to avoid this charge.** If you call with short notice due to an illness, injury, or emergency, the missed appointment charge will be waived. Should you arrive late for a massage appointment, your treatment will be shortened so as not to delay your provider for their next session; you will be billed for the full session. Our scheduling system can send a courtesy reminder via text before your visit; however the ***ultimate responsibility for keeping your appointment is yours.*** Note that 3 or more no shows or cancellations with less than 24 hour notice may result in being released from the practice.

Initial here: _____

Informed Consent

I understand and I am informed that, as with all health care treatments, results are not guaranteed, there is no promise to cure, and there may be risks associated with treatment. I further understand that I am responsible for monitoring my own condition throughout the treatments and will inform the doctor of any unusual symptoms that might occur. I intend this consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment in this office.

Reactions following chiropractic treatment often vary greatly from person to person. Most patients, however, report a great sense of well-being following an adjustment. Other reactions, such as tenderness and/or pain of the spinal joints or muscles may occur. This is due to joints beginning to move once again within their normal range of motion. This soreness will usually subside within a day or two.

Other more serious reactions, while very rare, include, but are not limited to, aggravating and/or temporary increases in symptoms, sprains or strains, fractures, disc injuries, dislocations, nausea, dizziness and strokes. Strokes are an extremely rare complication, estimated at 1 in 5.8 million people adjusted. It should be noted that the best scientific evidence available shows no direct causal relationship between adjustment and stroke.

Should you experience any reaction that concerns you following chiropractic care, please contact the office at (360) 373-2225.

FEES: I have read and understand the financial policy and agree to its terms.
CONSENT: I have read and understand the informed consent and agree to its terms.

_____ _____
Printed Patient Name Date

_____ _____
Patient Signature or Guardian Signature Relationship to Patient

SEE BACK SIDE →

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Chiropractic Lifestyle Center____.

I understand that the Notice describes the uses and disclosures of my protected health information by Chiropractic Lifestyle Center and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*