Mount Vernon Chiropractic
216 2nd Street SW
Mount Vernon, IA 52314
Dr. Jason R. Salier Dr. Randi J. Grafft

FINANCIAL AGREEMENT

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

Patients Without Insurance: We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing.

Group or Individual Medical Insurance: When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

Worker's Compensation: If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

Personal Injury or Auto Accident: Please notify your auto insurance carrier of your visit to our office immediately. Notify us immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

Medicare: We do accept assignment from Medicare. Medicare covers ONLY manual manipulation of the spine for Chiropractic. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. ******Please inform us of any secondary insurance you may have.

Insurance Authorization, Assignment of Benefits, Release of Information, Payment Agreement:
I understand that my insurance is an arrangement between my insurance company and myself, NOT between Dr. Grafft or Dr. Salier and my insurance company. I request that Mount Vernon Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits.

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Mount Vernon Chiropractic, LLC.

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Signature of Patient: _____ Date: _____
Signature of Guardian: _____ Date: _____

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Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, 'I' and 'my' refer to the patient, and
'Chiropractor' refers to Mount Vernon Chiropractic

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My 'protected health information' means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Mount Vernon Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are descried in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____

Date of Signing

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Consent for Examination and Treatment of Minor Child

I hereby authorize the doctors of Mount Vernon Chiropractic and whomever they may designate as their assistants to examine and administer chiropractic treatments as deemed necessary to my child _____(please print child's name) from this date forward. I have been informed of any risks associated with treatment and consent to Dr. Grafft or Dr. Salier treating my child accordingly.

Parent/Guardian Signature: _____ Date: _____

Address: _____

_____

Phone: _____

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PATIENT HISTORY

(Please Print)

Please check any of the following conditions you have had:

___ Anemia	___ Allergy	___ Arthritis	___ Alcoholism	___ Dizziness
___ Cancer	___ Asthma	___ Bursitis	___ Heart Disease	___ High Blood Pressure
___ Gout	___ Colitis	___ Diabetes	___ Emphysema	___ Multiple Sclerosis
___ Polio	___ Goiter	___ Epilepsy	___ Foot Trouble	___ Prostate Problems
___ Stroke	___ Ulcers	___ Headache	___ Tuberculosis	___ Rheumatic Fever

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Are you pregnant? No_____ Yes_____ If so, number of weeks pregnant:_____

Please list any past surgeries:

_____

_____

_____

Please list any fractures/injuries:

_____

_____

_____

Please describe any other health conditions:

_____

_____

_____

Please list any medication you are currently taking:

_____

_____

_____

Patient's Signature: _____ Date: _____

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PATIENT INTRODUCTION

(Please Print) Date _____

Name: _____ Social Security #: _____/___/_____
First Middle Last

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____ Age: _____ E-mail: _____

Employer: _____ Married: ____ Single: ____ Divorced: ____ Widowed: ____

How did you hear about the office? _____

Primary Complaint: _____

How long has this been a problem? _____

Is this complaint: Work Comp Related? YES NO Auto Accident? YES NO

In case of emergency who may we contact:_____ Phone Number:_____

INFORMED CONSENT

A patient, in coming to these Chiropractic Physicians, gives the doctors permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctors, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: Latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. This Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

I understand that if a physician at Mount Vernon Chiropractic accepts me as a patient, I am authorizing them to proceed with any treatment that may be necessary and understand the risks associated with such treatment. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request.

Patient's Signature: _____ Date: _____