Hill Chiropractic LLC 1035 W 5370 S Ste 175

Murray, Utah 84123 (801) 967-6000

OFFICE POLICIES & PROCEDURES AGREEMENT

FINANCIAL ARRANGEMENTS AND POLICIES

I understand and agree that health and accident insurance policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for products purchased and services provided by our office. Our office is a participating provider with a number of insurance companies. For your convenience, our office will make an effort to verify your insurance benefits. However, ultimately it's the patient's responsibility to determine benefits and authorization information before services are rendered. Please note that verification of benefits is not a guarantee of benefits. Your insurance company makes the final determination of insurance benefits when they consider the claim. It is understood that despite our best efforts to provide you with a financial estimate of the cost of care, times arise when insurance companies do not reimburse what was originally quoted. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company. If a referral is required but not provided at the time of your visit, full payment is expected at the time of service. Your signature below will give power of attorney to endorse checks made to **Bryce C. Hill, DC** to be credited to your account.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatment. Payment is due within 30 days of the service rendered. Bills that are delinquent more than sixty (60) days will be transferred to an outside collection agency unless prior arrangements have been made. Patients will be responsible for collection and/or attorney's fees for all such disputes which can be up to 50% of your balance. For any unpaid balances, that are 60 days past due, a monthly fee of 1.5% will be added to your balance. If there are legitimate problems, please discuss them prior to the sixty days so we may find a workable solution.

INFORMED CONSENT TO CHIROPRACTIC CARE

I request and consent to the performance of Chiropractic examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law of Utah, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by our office. I understand that results of the treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are associated risks with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

RECORDS RELEASE AUTHORIZATION & PERMISSION FOR CLINICAL RESEARCH

I hereby grant permission for **Bryce C. Hill, DC** to release any information pertaining to diagnosis and treatment of myself and care in this and other offices to my primary care physician, or to any other physician or therapist whom I am currently or previously under care with. I further authorize this office to utilize information pertaining to my care for the purpose of clinical research, publication and educational purposes, including the use of treatment records and videotaping of my treatment and management in this and other offices for the exclusive study of other Doctors. I realize the necessity of such purposes and understand that the highest ethical standards will be maintained in maintaining patient confidentiality. In accordance with all stated above, I hereby understand and agree to the above stated office policies.

PRINT Patient's Name: ____

SIGNATURE of Patient: ______________________________ Date: ________________

SIGNATURE of Parent or Guardian: ______________________ Date: ________________

Witness: ______________________________________ Date: ________________