Chiro Health Pro LLC
Dr. Martin Petrovic, DC
chirohealthpro.com

Mobile Practice
Portland, OR 97230
503-809-0800

FINANCIAL POLICY, HIPAA, & CHIROPRACTIC CARE CONSENT FORM

Clinic Financial Policy

Insurance Plans Billed – None.

_____ I, the patient, am responsible for paying out-of-pocket at the time of service. Chiro Health Pro LLC will provide the patient with a Super Bill/Invoice to submit to their insurance plan for reimbursement. Chiro Health Pro LLC does not accept payment from any insurance company except for personal injury claims (auto-accident and worker's comp).

Time of Service Fee Schedule

- New patient visit - 60 minutes - $130 / Routine follow-up visit - 30 minutes per 1 unit - $60

Missed Appointments or Late Cancellations: 24 hours' notice is required and appreciated.

Personal Injury Claims & Billing

- Auto accident and worker's comp related injuries require verification of an existing claim prior to examination and treatment.
- _____ If examination and treatment for auto and work-related injuries is not covered by any or all personal injury insurance companies involved, I, the patient, am responsible for all fees for treatment.

HIPPA Notice of Privacy Practices

Your protected health information may be used and disclosed by your physician, our staff, and others outside of this office that are involved in your care for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. All your information is strictly confidential.

_____ *I, the patient, consent to the use and disclosure of my Protected Health Information by Chiro Health Pro LLC.*

Examination & Treatment Consent

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound/laser, heat/ice application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications such as stroke are estimated to be in the range of 0.5 - 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back.

_____ *I have read and understand the above statements regarding treatment side-effects. I was made aware of procedures, alternative treatments, risks, and I was provided the opportunity to ask questions regarding recommended treatment(s) &/or procedure(s). I also understand that there is no guarantee or warranty for a specific cure or result.*

Please read the following carefully:

- _____ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, pacemaker, etc.), I should discuss this with the physician because it may affect care.
- _____ Notice to pregnant women: all females must alert their doctor if suspecting or having confirmed pregnancy as some therapies prescribed could present a risk to the pregnancy.
- _____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Chiro Health Pro LLC reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with payment and/or reasonable treatment plans.

By signing this application, I affirm that I have given true and complete information.

_____ _____ _____/_____/_____

Patient/Guardian (Print Name) Signature Date

_____ _____/_____/_____

Signature (Dr. Martin Petrovic or relief doctor) Date