Grand Teton Chiropractic, P.C.

Dr. James C. Gardner, DC

1220 East 17th Street
Idaho Falls, ID 83404
Phone: (208) 529-1919
Fax: (208) 552-9447

Notice of HIPAA and Financial Agreement

Please initial each line and sign at the bottom.

PATIENT NAME: _____ BIRTHDATE: _____

CONSENT TO TREATMENT

_____ *initial*

I hereby give consent and approval for myself/my child to participate in and be provided with diagnostic tests, evaluation, therapy procedures including massage therapy, and treatment by Dr. James C. Gardner, DC and/or staff of Grand Teton Chiropractic, P.C. I understand and hereby give permission that chiropractic treatment(s) and ancillary physiotherapy procedures will require the Provider(s) to have direct skin access to the patient's body, as deemed necessary by the provider. Furthermore, I hereby waive, release, and forever discharge Dr. James C. Gardner, D.C. and/or staff, representatives, or employees of Grand Teton Chiropractic, P.C. from any and all claims of damages, injury, or loss to persons or property.

PATIENT FINANCIAL AGREEMENT

_____ *initial*

I hereby request payment of authorized insurance benefits when applicable, to be made either to me or on my behalf to GRAND TETON CHIROPRACTIC, P.C. for any services furnished to me, or my dependent, by GRAND TETON CHIROPRACTIC P.C. I understand Dr. Gardner is an in-network provider with MEDICARE. I acknowledge liability for all medical expenses incurred whether or not the expenses are covered by insurance. Should any such expenses remain unpaid, such as insurance deductible, policy limits or exclusions, I agree to pay any amount remaining owed to GRAND TETON CHIROPRACTIC, P.C. This includes late fees, attorney's fees, and collection fees.

_____ *initial*

Each patient's co-payment is payable at the time of service. Where there is no insurance coverage, *payment is due on the date of service* unless other arrangements have been previously made. On all accounts more than 90 days past due interest will accrue at the rate of 1.5% per month on the remaining principal balance. Credits that may accrue on accounts from insurance write-offs or non-use by the patient are forfeit to the clinic after one year of said credit being applied to account. Inquiries regarding credits on account will be provided when requested. I acknowledge receipt of the extended financial agreement.

NOTICE OF PRIVACY SUMMARY

_____ *initial*

I authorize any holder of medical information about me/my child to release to the health care financing administration and its agents any information needed to determine these benefits of the benefits payable for related services. I further authorize the release of medical information to other medical, chiropractic, legal or other entities when deemed necessary.

_____ *initial*

I acknowledge that I was provided with the Notice of Privacy Practice (HIPAA) of the Chiropractic office named above.

_____ _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY **TODAY'S DATE**