FINANCIAL POLICY

At Thrive KC- Chiropractic & Family Wellness, we understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy, a member of our staff will be glad to assist you.

SELF PAY

- We request that 100% of all visits be paid at the time of service.
- We gladly accept cash, checks, credit cards, HSA, and flex-pay cards
- Our office has established a single-fee schedule that applies to all patients for each service provided based allowable limits determined to be reasonable and customary for the state of Kansas. We cannot offer "cash" or time of service discounts greater than 15% below these rates.

Cancellations of any appointment should be made 24 hours in advance to avoid a $25 service fee. There is also a $25 service fee if a patient 'no call, no shows' for their appointment. Reschedules should be confirmed and done directly with the front desk. The Doctor is the only one qualified to change your treatment schedule.

When you pay by check you expressly authorize this office, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms.

Financial arrangements are valid under your present condition. They are subject to renewal by the start of each new year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify the office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification.

Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney, small claims court, or agency for collections. You will be responsible for all charges related to this collection process. Please keep your account current to avoid any action or blemish on your credit history.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions.

I have read, understood, and agree to this Financial Policy in its entirety.

Printed Name: _____

Signature: _____ Date: _____

PATIENT PRIVACY POLICY

This practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in this office. With consent from you, it is the policy of this office to use your PHI in the following manners:

1. Treatment: Your PHI will be given to those professionals that require it to provide care.
2. Appointment Reminders: Our staff may call from time to time to remind you of appointments.
3. Sign-In Log: We maintain a log of incoming patients for our own statistical use.
4. Referral Board: We keep a board to thank members of our practice who have referred others.
5. Medical Doctors: It is the policy of this office to share our findings with your regular medical doctor, if co-treating is necessary for your care. This helps build a better understanding of how we may work together to improve your health.

In special circumstances, your PHI may be disclosed as in the following:

1. Personal Representative: In accordance with applicable law that may represent you.
2. Emergency Situations
3. Abuse, Neglect, or Domestic Violence
4. Law Enforcement Issues
5. Worker's Compensation Claim
6. Avert a Health Threat

Your rights regarding your health information:

1. Right to inspect and copy your records. A written request must be submitted and cost of copying may be applied to such a request.
2. Amend your PHI by submitting a written request with an explicit reason.
3. Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.
4. Revoke consent at any time.
5. Complain to the practice.

Printed Name: _____

Signature: _____ Date: _____

CONSENT TO TREAT

The primary treatment used by Doctors of Chiropractic is the spinal adjustment.
We will use this procedure to treat you.

The nature of the chiropractic adjustment.
We will use our hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in a chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including vertebral artery dissection (stroke). Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of bone, which we check for during the taking of your history and during examination/x-rays. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that type of injury. The other complications are also generally described as "rare."

The availability and nature of other treatment options.
Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care with prescription drugs, such as anti-inflammatories, muscle relaxants, and/or pain killers.
- Hospitalization with traction.
- Surgery.

The material risks inherent in such options and the probability of such risks occurring include:

- Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work, and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, patient's pain tolerance, and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
- Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, patient's pain tolerance, and self-discipline in not abusing the medicine. Such medications generally entail very significant risks- some with rather high probabilities.
- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse results from such exposure dependent upon variables.
- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies to many factors.
  ***Haldeman, Scott, D.C. M.D.**

The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Do not sign until you have read and understand the above.
Please check the appropriate box and sign below:

I **have read [ ] or have had read to me [ ]** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my Doctor of Chiropractic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Printed Name: _____
Signature: _____
Signature of Parent or Guardian (if a minor)

Witness:

_____(Printed name)
_____ __(Signature)

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Dr. Bethany Long and whomever she designates as assistants to administer examinations and chiropractic care as deemed necessary to:

_____ _____

Minor Patient's Name D.O.B.

_____

Printed Name of Parent/Guardian

_____

Signature of Parent/Guardian Date

_____

Witness Date

Parent/Guardian Remarks: _____

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