

Welcome to Anatomy Power

FINANCIAL AGREEMENT

All our services are paid on the date of service. We have Wellness Plans and Family Plans that make your care affordable and cost effective. It is your responsibility to call us to make your appointments. Our Wellness Plans expire one year from the date of purchase. If you stop making appointments you may lose your care plan. If you choose to discontinue your care within the year, the cost of your care will be calculated at the full fee rate. You will either be responsible for the outstanding balance or receive a refund minus the regular undiscounted care within 2 weeks of your notification to us. We are happy to bill your insurance as a courtesy at the customary insurance rates for an extra cost but we do not rely on insurance to pay our fees. If your health insurance mails you checks as a result of our insurance billing, they are NOT to be cashed. Bring the checks to our office as they are payments to Anatomy Power Wellness Studio. Our cancellation/missed appointment policy requires 24 hour notification if you cannot keep your appointment, otherwise you pay for that missed appointment and/or we deduct one visit from your care plan.

HIPPA: PRIVACY CONFIDENTIALITY STATEMENT

We may disclose information to other healthcare professional and/or your insurance carrier for treatment, payment or healthcare options. Additional disclosures may be necessary to comply with Worker's Compensation and public health laws as well as judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made. I have read this privacy notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

ARBITRATION AGREEMENT AND INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, and wellness advice including various modes of physical therapy, clinical blood testing, nutrition counseling, vitamin therapy, referral for diagnostic x-rays and MRI, and massage therapy for me (or the patient named below for whom I am legally responsible) by the Anatomy Power doctors, and/or other licensed doctors of chiropractic who now or in the future may treat me while employed, working/associated with, or serving as back-up for the Anatomy Power doctors. I have had the opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, and in my best interest. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to chiropractic and wellness care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I see treatment.

I understand and have read the above. I agree to meet my financial responsibility as described above:

Patient Name (Please Print)

Patient Signature

Date