## FINANCIAL AGREEMENT

Review and sign the following Financial Agreement in its entirety prior to your first appointment. This financial agreement will remain in place, unless given notice by the office *(GatesChiropractic) Mobile Chiropractic Health w/ *Equine, Canine* of any payment changes.

Services provided by *(GatesChiropractic) Mobile Chiropractic Health w/ Equine, Canine (hereinafter MCH *w EC*) are not billable through your insurance provider; meaning *GatesChiropractic.com MCH *w/ EC* will not accept your insurance information and bill any patient charges for you through them. By eliminating this third party, it allow MCH *w/ EC* to administer the treatment that is felt necessary for the patient's best interest. It is *GatesChiropractic , MCH *w/ EC's* policy that payment is collected same day of service or prior to service if a pre-payment option has been elected,. *GatesChiropractic , MCH *w/ EC* accepts cash, personal checks, and credit cards for payment on your account.

I _____(printed patient name) agree to pay for services at the time of service, or prior to service rendered, if responsible financial party is to the aove named patient, they are signing this document stating that as of this date, they have the legal right to select and authorize health care services for the printed patient named above and that they are also accepting financial responsibility for the treatment of the above named patentor MCH w/ EC services. It is the responsibility of the authorized signature below to inform the office of MCH w/ EC of any financial or legal changes.

_____ _____
Printed name of above named patient or responsible party Date

_____ _____
Signature of above named patient or responsible party Date

## PATIENT CONSENT FORM (HIPAA COMPLIANCE)

I understand that some of my information may be used and/or disclosed by *(GatesChiropractic) Mobile Chiropractic Health *w/ Equine, Canine* to carry out treatment, payment, or healthcare operations. I understand that I may request restrictions on how my information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that I can revoke this consent, bu only in writing.

*(GatesChiropractic) Mobile Chiropractic Health *w/ Equine, Canine* keeps a record of the healthcare services provided to you. You may ask to see and copy that record. You may also request to correct that record. We will not disclose your record to others, unless you direct us to do so, or unless the law compels us to do so. You may see your record by contacting *(GatesChiropractic). Mobile Chiropractic Health *w/ Equine, Canine.*

_____ _____
Patient signature Date


***Please keep MCH w/ EC informed of any changes to personal information or health issues as they arise.***