**Financial Policy/Payment Information**

Please give any insurance information you may have and a copy of your insurance card to our Front Desk Staff. We will be happy to determine coverage for you. Please remember this is an only an estimate of care, and NOT a guarantee of benefits. Clinic policy requires that payment is due at the time services are rendered.

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible.

I have read and understand the payment policy of Dr. Courtney Lehmen & Dr. Marcy Cooper. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Courtney Lehmen & Dr. Marcy Cooper that fees will be due and payable immediately. I agree that I will be responsible for all attorney and legal fees if action becomes necessary to collect on this account. For any returned checks there is a $30 Fee. If you No Call / No Show for an Appointment, there is a $45 Fee.

Please indicate below how you will be taking care of this account:

* Health Insurance
* Medicare
* Cash/Check/Credit Card
* Auto Insurance
* Personal Injury
* Worker’s Compensation

**Consent To Treat**

The primary treatment used by doctors of Chiropractic is the spinal adjustment. The doctor will use her hands or a mechanical device upon your body to deliver such spinal adjustment. The doctor may also use other physical modalities such as electric stimulation, ultrasound, cold laser, mechanical traction, aqua massage, acupuncture, and massage as part of your treatment. While rare, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to: sprain/strain, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, and dislocations. By signing below you are giving consent to treatment. I intend this consent form to cover the entire course of treatment for my present and any future condition(s) for which I seek.

**HIPAA Notice of Privacy Practices**

This paperwork is available for you to view and read on our website if you would like to do so.

**Assignment of Benefits**

I authorize the direct payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to Dr. Courtney Lehmen and/or Dr. Marcy Cooper as payment for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Patient’s signature (or guardian if patient is a minor) Date