

Gardner Wellness Center

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME SERVICE IS REQUIRED.

If this account is assigned to an attorney/or outside agency for collection and/or suit, Gardner Chiropractic shall be entitled to reasonable attorney's fees and for cost collection.

I authorize the release of any information necessary to determine the liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE

INSURED'S SIGNATURE

DATE

INSURANCE ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Gardner Wellness Center to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier (s) necessary to process my insurance.

AUTHORIZATION TO PAY BENEFITS:

I hereby authorize my insurance carrier(s) to make payment directly to Gardner Chiropractic and/or medical benefits payable for the services rendered.

PATIENT SIGNATURE

INSURED'S SIGNATURE

DATE

PRACTICE'S REQUIREMENTS

The Practice:

- (a) Is required by federal law to maintain the privacy of you PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
- (b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law
- (c) Is required to abide by the terms of the Privacy Notice
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
- (e) Will distribute any revised Privacy Notice to you prior to implementation
- (f) Will not retaliate against you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 7/26/04

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of the Notice, and my understanding and my agreement to its terms

PATIENT

DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of the Notice could not be obtained because:

- Patient refused to sign
- Communication barrier prohibited obtaining acknowledgment
- Emergency circumstances
- Other

Details:

Signature of Practice

Date

AGREEMENT TO DO A “NUTRITION RESPONSE TESTING™” PROGRAM

I specifically authorize Gardner Wellness Center to use a Nutrition Response Testing™ health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or “cure” of any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that this is not a method for “diagnosing” or “treating” of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, but rather I understand that T:\HealthSource Forms\Current Front Desk Forms\Agreement To Do NRT Program.docit is a means by which the body’s natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

PATIENT PRINT NAME

PATIENT SIGN NAME

DATE

WITNESS PRINT NAME

WITNESS SIGN NAME

DATE

I, the undersigned, am providing Gardner Wellness Center with my email address. I understand that by providing my email address to Gardner Wellness Center you have my permission to communicate with me via email. I also understand that Gardner Wellness Center will not share or provide my street address, phone, fax, no email address in any way, for any reason, to any third party. I also understand that I can request to have my street and email address removed from Gardner Wellness Center's list at any time. On this basis, my current email address is provided below:

Printed Name

Email Address

Phone

Fax

Signature