WARWICK CHIROPRACTIC AND MASSAGE

8650 Martin Way E #207, Lacey WA 98516

CONSENT TO TREATMENT AND BILLING INFORMATION

Our office will provide insurance billing services for you as a courtesy. Your health insurance benefits are based on a contract between you and your health insurance carrier and **any benefits quoted are not a guarantee of payment**.

I authorize direct payment of medical benefits, from my insurance company to Dr. David M. Warwick and associates, Warwick Chiropractic and Massage, any and all healthcare provider employees of Warwick Chiropractic and Massage, and / or supplier for any services performed at this office. I also authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party that accepts assignment.

It is understood that all reasonable efforts will be made to collect from my insurance company, and final determination of payment will only be made after claims have been received and processed.

I understand that any and all amounts which are not collected from my insurance company shall become my responsibility, and I agree to pay those charges within 30 days. I further agree that any insurance reimbursement check that I receive directly from the insurance company (usually if our office is out of network), shall be transferred to Dr. David Warwick in full within 10 days of my receipt of the check. If I owe a deductible or co-pay for my treatment, I agree that I shall make all reasonable efforts to pay at time of service unless otherwise agreed upon. I understand that it is my responsibility to pay any deductible amount, copays, coinsurance, and / or any other balances that are not covered by my contract or paid by my insurance carrier.

I understand that motor vehicle accidents and workers' compensation cases with outstanding balances, as well as all other past due accounts that are sent to collections 120 days or more after the first statement I receive, will be charged 9% interest fee annually. I also understand I am responsible for lien fees associated with filing medical liens with the county auditor.

If I am not covered by any type of insurance, I understand that I am responsible for my bill in full. My bill may be additional services in addition to a chiropractic adjustment, including but not limited to: initial examination, progress / update exam, cold laser therapy, and/or any other services provided by doctors in our office that are in addition to a chiropractic adjustment.

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the tests, diagnosis, and analysis. The chiropractic adjustments, spinal decompression, massage therapy, or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if they are aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures, whatever s/he is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I understand that if I am accepted as a chiropractic patient at Warwick Chiropractic and Massage, I am authorizing Dr. David Warwick, and any licensed healthcare provider employees of Warwick Chiropractic and Massage, to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic, spinal decompression, or massage treatment, will be explained to me upon my request. I agree with the current or future recommendation to receive chiropractic, massage, and/or spinal decompression care as is deemed appropriate for my circumstance. By signing below, I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) from which I seek care from this office.

I acknowledge that I have received the practice's Notice of Privacy Practices for protected health information.

Full name_____Date_____

Signature_____