Dr. Rachel M. Hamel, DC

PATIENT AGREEMENT

This agreement is designed to familiarize you with our office policies. Please **READ** and **INITIAL** after each paragraph where indicated. Then SIGN this document and be assured that you will be receiving the very best care available.

PAYMENT POLICY
Payment is expected at the time services are rendered.

Non-Insured
In an effort to reduce the paper if you need a statement for tax or bookkeeping purposes, upon request we will provide an itemized statement at the end of the calendar year. If you need a statement to submit to your HSA, Flexible Spending Account, or cafeteria plan we will provide you with a superbill at the time of your visit.
Initials_____

Health Insurance With Out-of-Network Chiropractic Benefits
Payment is expected at the time services are rendered.
We will provide you with a superbill that you can submit to your carrier for processing after each visit.

Dr. Hamel DOES NOT promise that an insurance company will pay. Nor does she promise that an insurance company should pay the fees as charged. Dr. Hamel will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

Please sign the following statement which authorize us to release information about you to your carrier should they request it: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process my claims.
Signature_____ Date_____

Initials_____

Medicare
We are a "Non-Participating Provider with Medicare". As a Medicare provider we are required to submit claims to Medicare for you, however, as a "non-participating provider" we are do **not** accept assignment therefore, you will be required to pay for all services in full at the time of service. Medicare should send reimbursement directly to you for covered services. If you have a supplemental, secondary or medigap policy Medicare should send claims directly to them for you. Please complete the following authorization:
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process my claims..
Signature_____ Date_____

Initials_____

Medi-Cal
If you are a **Medi-Cal** patient, please note that we are not a Medi-Cal provider and therefore all service need to be paid for in full at the time of service.
Initials_____

Workers' Compensation:
Because we are a "cash" practice we do not treat work related injuries. If you are injured on the job, please contact your employer for a referral.

Initials_____

GENERAL OFFICE POLICIES

Voluntary Termination of Care:
Outstanding fees for professional services rendered will be immediately due and payable for patients who choose to suspend or terminate care.
Initials_____

Rescheduling Appointments:
If you find it necessary to change the time or day of a scheduled appointment, please call or stop by, we will reserve a new time and or day so you don't miss any of the care necessary to help you move towards your desired outcome. If you miss an appointment it should be rescheduled for later that day or the next available appointment. **All scheduled appointments are necessary!** If you miss one scheduled office visit without giving 24 hours notice, there will be no charge. If you miss a second office visit time there will be a charge of $95. Additionally, we should re-evaluate what you want as an outcome from the care you receive at our office.
Initials_____

Fees:
- There is no charge for a 10 minute telephone consultation with Dr. Hamel.
- The fee for a thorough chiropractic, orthopedic and neurological examination fees range from $200-275 depending on the complexity of your case.
- Chiropractic adjustments ranges from $95-110 per visit depending on the number of regions adjusted.
- There will be additional charges for any physical medicine and rehabilitation services and for nutritional supplements and orthopedic supports.

Initials_____

Doctor/Patient Communication:
Communication is essential. All questions, comments, and suggestions are welcome. If you have a new illness or injury, please call to schedule and examination. Please remember this,

"The most dangerous thing about communication is the assumption it has taken place!

Methods of Payment:
The forms of payment we accept are: Cash, Check, ATM/Debit Card, MasterCard, Visa, Discover, American Express

Notice of Privacy Practices
I have received a copy of this office's Notice of Privacy Practices.
Initials_____

(A copy of this form can be provided upon request.)

_____ _____
Patient or Parent / Guardian Signature Date

_____
Print Name of Patient and / or Name of Signature