

FINANCIAL & PAYMENT AGREEMENT

I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage, including deductibles, copayments and coinsurance. Jennifer Hess is a participating or preferred provider with many health insurance plans. However, plan participation is subject to change and does not cover all provided services. I understand that it will be my responsibility to verify with my insurance carrier the plan participation status of Dr. Hess and level of chiropractic care coverage. Insurance will be billed according to the billing/payment guidelines of my primary insurance as a courtesy to patients. Charges will be my responsibility if I fail to provide accurate insurance information.

I understand that if I suspend or terminate my schedule of care as determined by Dr. Hess any fees for professional services will be immediately due and payable. I also understand that I may be billed a fee of \$42 for missed appointments that are not canceled 24 hours in advance, with the exception of emergencies.

Patient or Guardian Signature

Date

Print name of patient or guardian

PATIENT COMMUNICATION AUTHORIZATION

Dr. Hess may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. Contact may also be made via email. By signing this form, you are giving Dr. Hess authorization to contact you with reminders.

Patient or Guardian Signature

Date

MEDICAL RECORDS ACCESS AND RELEASE OF INFORMATION

In conjunction with care by Jennifer Hess, DC, there may be additional records, imaging and imaging reports, lab results, and related medical records that may be of assistance in correlating your treatment. **I agree to allow Jennifer Hess, DC access to those pertinent medical records.** Any authorization I provide regarding the use and disclosure of my health information may be revoked at any time *in writing*. After I revoke I authorization, Hess Chiropractic will no longer use or disclose my information I for the reasons described in the authorization.

Also, I hereby authorize Jennifer Hess, DC to furnish my insurance company, employer, other payers and their representatives any and all information required to process my claims. I understand that Jennifer Hess, DC will obtain special permission if it is necessary to release information related to treatment for drug/alcohol abuse, mental health or HIV related conditions.

By signing this section I acknowledge that I understand that I am giving access to my personal medial records. A copy of this authorization is as valid as an original.

Patient or Guardian Signature

Date