Locust Grove Clinic P.C.
835 Jackson St.
Locust Grove, Ga. 30248

Office Policies

Please read carefully, initial each paragraph, and sign at the bottom.

_____ Failure to give 24-hour notice of Cancellation will result in a $25.00 broken appointment fee.

_____ If you are more than 15 minutes late, we MAY reschedule your appointment. Please call if you are running late and we will reschedule you as close to your appointment time as possible.

_____ **This office is now paperless. All patient records are kept in an electronic format. All original paper documents will be scanned and the originals will be shredded.**

_____All products sold in our office are non-returnable.

_____I Understand That Chiropractic Is Not An Exact Science And Therefore Reputable Practitioners Cannot Guarantee Results. I Acknowledge That No Guarantee Or Assurance Has Been Made By Anyone Regarding The Chiropractic Treatment That I Requested And Authorized. I Understand That Each Doctor Is An Individual Practitioner And Is Individually And Solely Responsible For The Care Rendered To Me And Any Associated Financial Matters.

I agree that my contact information may be used for appointment reminders, emergency updates and occasional messages from the doctor or staff about special event, sales or promotional events.

What is your cell number? _____
Can you receive Text messages for appointment reminders? Y N

I have read and understand the information in the "What can I expect" section of the New Patients tab on the clinic website locustgroveclinic.com.

I HAVE READ AND AGREE TO ABIDE BY THE ABOVE POLICIES.

Patient Name: _____ Date of Birth: _____

_____

(Patient/Guardian Signature if under 18) (Print Name if other than Patient) (Date)

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Office Financial Policies

YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR CARRIER.

Please read carefully, initial each paragraph, and sign at the bottom.

_____ All co-pays, co-insurance and deductible amounts are due at the time treatment is performed. Charges are based on your insurance company's fee schedule. You are responsible for non-covered or excluded services.

_____ We will file your insurance claim. We will provide your insurance carrier any required documentation necessary to pay claims. Should your insurance company refuse to pay a claim, for any reasons that are not related to medical necessity, contracted fee schedules, or PPO discounts, you will be responsible for payment of our normal fees.

_____ We will notify you in writing when claim processing leaves you with a balance.

_____ Your insurance carrier must provide you an Explanation of Benefits. It is your responsibility to read this. If the "Patient Responsibility" amount is different from what you paid us, contact the office immediately to settle the difference.

_____ Should our office owe you a refund due to insurance mishandling, misinformation, or incorrect claims processing, we reserve the right to have all disputed charges appealed and the appeals finalized before a refund check is issued.

_____ All balances are your responsibility. Non-Payment within 90 days will result in third party administration of your account and a $28 fee. An account over 60 days will incur a 1.5% finance charge based on unpaid balance. These charges will accrue each month on the 1st of the month for every month there is an outstanding balance, starting from 60 days after the first bill you receive. We reserve the right to submit your personal information to any agent we deem necessary to collect the balance that is due.

_____ Returned checks, stop payments and credit card charge backs incur a fee of $25.00 or 5% of the face amount, whichever is greater, and an amount equal to the charges incurred by our bank.

_____ If you have an auto accident claim, we expect to be paid at 100% of our normal fee schedule. If any third party, such as a lawyer or insurance company does not pay your full bill, **you will be responsible for the balance**.

I HAVE READ AND AGREE TO ABIDE BY THE ABOVE POLICIES.

Patient Name: _____ Date of Birth: _____

_____

(Patient/Guardian Signature if under 18) (Print Name if other than Patient) (Date)

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, traction or massage may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, bums or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks associated with these medications increase with greater use, include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. Preventable surgical errors - while statistically a small percentage of total procedures - increase the risk of negative outcome.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

PRINT Name: _____ **DOB:** _____

SIGNATURE: _____ **DATE**: _____

WITNESS Print Name: _____ DATE: _____

SIGNATURE WITNESS: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Locust Grove Clinic P.C.** I understand that the Notice describes the uses and disclosures of my protected health information by **Locust Grove Clinic P.C.** and informs me of my rights with respect to my protected health information.

I understand that **Locust Grove Clinic, PC/Dr. Elizabeth C. Tully** will provide me with a copy of my records at my request.

I may request a ***clinical summary*** at the time of treatment and this will be available within one (1) day. This may be as a printed record, in encrypted email (if available) or through an online portal called Health Vault.

I may have ***online access*** to my record within four (4) business days through Microsoft Health Vault.

Patient's Signature or that of Legal Representative	*Printed Name of Patient or that of Legal Representative*
Today's Date	*If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name: _____ *Date:*_____