Dr. Pete's Chiropractic

Consent to Treat

_____ I authorize the employees of Dr. Pete's Chiropractic to treat within the scope of their respective licenses.

Billing Policy

_____ I understand the terms of my insurance policy. I understand that it is my responsibility to monitor the costs and limits of coverage of my benefits. I understand that I am liable for all costs incurred due to any or all the following: deductible, co-pay, co-insurance, and *treatment exceeding the limits of my benefits*.

- For In-Network Patients, Co-pays, and coinsurance will be collected at the time of service per our contractual agreement with your insurance company
- We will enter contractual write-offs and amount paid by your insurance company into our system and will bill you for the remaining portion.
- We will send you a billing statement to the mailing address you provide on the next page.
- If payment is not made, we will attempt to call the number provided.
- Balances outstanding after 6 months of attempted contact will be turned over to a collections agency.

Cancellation Policy

_____ Please call us at 970.925.8940 at least 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 5:00 p.m. on Friday. If prior notification is not given, you will be charged a $100 (Physical Therapy) or $95 (Chiropractic) "No Show" fee for the missed appointment.

Privacy Notice

_____ I have reviewed and was offered a copy of the Dr. Pete's Chiropractic's Notice of Privacy Practices. I understand that I may contact the privacy officer (Dr. Peter Scher, 970.925.8940) with any questions.

How did you hear about us? ___ MD referral ___ Friend/Family ____ Radio ___ Club Member ____ Club Employee ___ Previous Patient ___ Internet ___ Newspaper

Printed Name_____ Signature_____

Date_____ DOB_____