Boyer Chiropractic
& Wellness Center

Jamie Boyer DC FDN-P

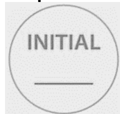
APP'T
DATE:______________________
TIME:__________________________

Name: Last:__________________________________ First:________________________ MI:_____
Permanent Address:__________________________________ City:_____________________ State:____
Zip:_______
Birth date: ___/___/____ Male: ___ Female: ___ (**Female: Is there a chance you could be pregnant?) Y- N**
Phone:_____________________________________
Employer:___________________________________ **Occupation:**___________________________
Emergency Contact:___________________________ **Phone:**_______________________________

Insurance Assignment

1. **Co-pays and deductibles** will be collected.
2. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company & accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and supportive health care program is recommended. We will notify you of the change.
3. All Deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility (usually 20%). This must be paid at least weekly. Prepayments may also be made.
4. The insurance carriers are billed on specific 15-30 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
5. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check to this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action.
6. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
7. This clinic does not promise that an insurance company will pay.
8. Payments are due the day of visit unless previous arrangements have been made.

I authorize the Doctor to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provision as specified above.



Terms of Acceptance

When a patient seeks chiropractic health care and/or health coaching services, and we accept a patient for such care; it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

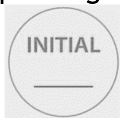
VERTEBRAL SUBLUXATION: A misalignment of 1 or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding

treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our main method is specific adjusting to correct vertebral subluxations.

Consent for Purposes of Treatment, Payment, and HIPAA Acknowledgement

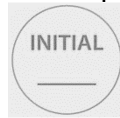
I acknowledge that Boyer Chiropractic and Wellness Center "Notice of Privacy Practices" has been provided.

I understand I have a right to review Boyer Chiropractic and Wellness Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Boyer Chiropractic and Wellness Center. The Notice of Privacy Practices is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Boyer Chiropractic and Wellness Center's duties with respect to my protected health information. Boyer Chiropractic and Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.



Health Coaching/Nutritional Counseling

The undersigned client agrees to abide by the guidelines of Boyer Chiropractic and Wellness Center's health coaching services, including the completion of the medical questionnaire.
The undersigned client agrees that all use of health coaching services and programs shall be undertaken at his (her) sole risk. Boyer Chiropractic and Wellness Center shall not be liable for any injuries, accidents or deaths occurring to clients arising either directly or indirectly of utilizing our health coaching services and programs.
The client, for himself (herself) and on behalf of his (her) executors, administrators, heirs and assigns, does herby expressly release, discharge, waive, relinquish, and covenants not to sue Boyer Chiropractic and Wellness Center, its officers and agents for such claims, demands, injuries, damages or cause of action, with respect to use of our health coaching services and programs.
The undersigned client declares that after completion of the medical questionnaire required prior to any health coaching services and programs, Boyer Chiropractic and Wellness Center will advise the client to obtain a medical clearance in the event they have any potential medical restrictions, and/or are unsure of their physical health that may limit he (she) in being physically capable of pursuing any activity in our health coaching program. I have read and fully understand the above statements. All questions regarding Boyer Chiropractic and Wellness Center's objectives pertaining to my care in this office have been answered to my complete satisfaction.



I agree to the above terms.

____ **DATE**______________________________

Patient or Personal Representative

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Jamie Boyer DC FDN-P

OFFICE USE ONLY

INSURANCE:____
ID:____

GROUP NUMBER:___________________________ CO-PAY:__________ DED.
AMT:_____________________________________

Non-embedded or aggregate