

**FINANCIAL INFORMATION**

     Thank you for choosing us as your healthcare providers.  We are committed to your treatment being successful.

**FEES & PAYMENTS**

Our fees are based upon reasonable and customary charges.  Fees for a visit or new condition are higher than the routine follow up because more time is required to diagnose and treat than to follow an existing one.  Capitol Rehab bills each modality rendered at the time of service.  Treatment costs vary depending on the type of treatment deemed medically necessary.

**DEDUCTIBLE**

**If your insurance policy has a deductible, it is Capitol Rehab of Winchester’s policy to keep a credit card on file.**

**Please note, that unless payment arrangements are made in advance you will be responsible for any outstanding balance on your account at the end of each billing cycle.**

**MISSED APPOINTMENT POLICY**

Please understand your doctor has prescribed therapy for you and chiropractic is an ongoing process which requires regular attendance in order to be optimally effective. Please be on time for your appointments so you may be given the full benefit of your scheduled treatment. A late arrival of greater than 15 minutes may result in shortened treatment or cancellation. Since our primary purpose as a business is to help people, we require 24-hour advance notice to cancel a scheduled appointment. By giving us sufficient notice when cancelling an appointment, we can fill your scheduled time slot with someone else who needs our services. Failure to show for an appointment will incur a $50.00 fee, cancellation without 24 hour notice will be subject to a $25.00 charge.

**CREDIT CARD ON FILE**

**Unless co-payment/co-insurance payment is made in full each visit, it is our policy to keep a credit card on file.**

Credit Card Number:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:  \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

CVCC (Security #):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Box #) (Zip Code)*

Name on Card:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⃞    I authorize the above credit card to be charged each visit the allowed amounts of my treatment until my deductible of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is met. \*\*

⃞    I authorize the above credit card to be charged each visit for my copay/co-insurance amount of $\_\_\_\_\_\_\_\_\_\_. \*\*

**\*\*Be advised that your credit card will be charged immediately for any missed appointment. If there is any additional outstanding balance you will be charged at the end of the billing cycle unless payment arrangements have been made prior to your visit.**

***I understand that my insurance will be billed for services rendered.  We will make every attempt to obtain payment from the insurance.  If the insurance denies the claim(s), I understand that my credit card on file will be charged for the full amount.***

I understand and accept the above policies,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature                                    Date



**INFORMED CONSENT**

**Chiropractic/ Physical Therapy**

Chiropractic and physical therapy care seeks to restore health through natural means without medicine or surgery.  This gives the body maximum opportunity to utilize its inherent recuperative powers.  The success of the doctors’ procedures often depends on the environment, underlying causes, physical and spinal conditions.  It is important to understand what to expect from chiropractic and physical therapy health care services.

**Diagnosis**

Although the doctors at Capitol Rehab of Winchester are accomplished in chiropractic/physical therapy diagnosis, they are not internal medicine specialists.  Every chiropractic/ physical therapy patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition.  Our doctors may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

**Informed Consent Regarding Chiropractic and/or Physical Therapy**

As a patient, you give our doctors permission and authority to care for you in accordance with the chiropractic/ physical therapy tests, diagnosis and analysis.  The chiropractic adjustment/ therapy treatment or other clinical procedures are usually beneficial and seldom cause any problem.  In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury.  Our doctors, of course, will not give a chiropractic adjustment or physical therapy treatment, if they are aware that such treatment may be contraindicated.  Again, it is the responsibility of the patient to make it known or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of our doctors.  The patient understands and is informed that, as in all health care, in the practice of Chiropractic and Physical therapy medicine there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries and strokes.  The patient should look to the correct specialist for the proper diagnostic and clinical procedures.  Our doctors provided specialized, non-duplicating health service.  Our doctors are licensed in a special practice and are available to work with other types of providers in your health care regime.

**Results**

The purpose of chiropractic and physical therapy services is to promote natural health by allowing the body the opportunity to use its inherent recuperative powers.  Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic and physical therapy treatments.  Sometimes the response is phenomenal!  In most cases there it is a more gradual but quite satisfactory response.  Occasionally, the results are less than expected.  Similar conditions in different people respond differently to the same chiropractic or physical therapy treatment.  We can never guarantee a cure for your condition, although many medical failures find relief through chiropractic and physical therapy.

**Minor (If Applicable)**

I/We, the undersigned, parent(s)/person having legal custody/ legal guardianship of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby authorize the providers of Capitol Rehab of Winchester, as agent(s) for the undersigned to consent to any examination and physical therapy diagnosis or treatment, which is deemed advisable by a licensed Physical Therapist and/or Chiropractor, be rendered under general or special supervision of any licensed Physical Therapist and/or Chiropractor. This authorization remains

**Minor:** I/We have read and understand the above information and consent to treatment from this point forward until written notice is provided 30 days in advance or upon the minor’s 18th birthday.

**Adult:** I have read and understand the above information and consent to treatment from this point forward until written notice is provided 30 days in advance.

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Signature Date