Spring Spine Center
6535 FM 2920, Suite 200
Spring, Texas 77379
(281) 376-1288 Fax (281) 378-4706

This form must be read and signed in order to see the doctor.

Financial Policies

Our purpose is to provide the very best chiropractic care possible. One of the ways we accomplish this is to eliminate potential problems that may detract from the quality of our work. Therefore, we have developed the following financial policies:

We will verify your insurance coverage and review your benefits with you. It is your responsibility to keep up with any maximum limitations that your policy imposes. Keep in mind that verification of benefits is not a guarantee that your insurance company will pay for all services rendered. You may request a copy of your verification page at any time.

As a service to our patients, we will bill your insurance company for your treatments. Any unpaid balance that your insurance company has not paid will become your responsibility. Unless otherwise stipulated, the insurance contract is between the patient and the insurance carrier, not between the doctor and the insurance company.

All co-payments MUST be paid at the time services are rendered. Should any patient wish to make monthly payment arrangements, please see the office manager for additional information.

A current copy of the patients' insurance card is required in order to file claims. All services received prior to insurance verification must be paid in full at the time services are rendered. When the dates of service in question are paid in full by your insurance carrier, all over-payments will then be credited to the patients account.

Should your insurance carrier change during the course of treatments or between visits, it is patients' responsibility to update their insurance information with the billing department.

Initial_____

Referrals

It is the patient's responsibility to obtain referrals when necessary from their primary care provider prior to treatment. I agree to pay in full for all services rendered without the required referral.

Initial_____

Consent to Treat Minor

I hereby authorize **Dr. Smith** and any staff member he may designate as assistants to administer chiropractic care as deemed necessary to my child for the course of my child's treatment.

Initial_____

Chiropractic Safety and Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor **(Dr. Steven S. Smith, D.C. / Dr. Jessica Kemp, D.C. / Dr. Zach Ratcliff, D.C. / Dr. Jacob Navarro, D.C.)** to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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Signature of Patient/Guardian **Date**

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Witness Signature **Date**