Jennifer A. Hess, DC, PhD * 1907 Garden Ave., # 102, Eugene, OR 97403 * 541.844.4070 * www.hesschiropractic.net

FINANCIAL/PAYMENT AGREEMENT

I understand that I am responsible for the costs of chiropractic care, regardless of insurance coverage, including the deductibles, co-insurance, copayments and non-covered services. Jennifer Hess is a participating or preferred provider with many health insurance plans. However, plan participation and benefits vary and are subject to change and may *not* cover all provided services. A quote of benefits to Dr. Hess by an insurance company is NOT a guarantee of payment or coverage. I understand that it will be my responsibility to verify with my insurance carrier the plan participation status of Dr. Hess and covered benefits prior to service being rendered. Insurance will be billed according to the billing/payment guidelines of my insurance. However, **ALL** charges will be my responsibility if services are not paid by my policy for any reason (such as if benefit limits being reached or misquotations of benefits).

I understand that if I suspend or terminate my schedule of care as determined by Dr. Hess, any fees for professional services will be immediately due and payable. I also understand that I may be billed a fee of $45 for missed appointments that are not canceled 24 hours in advance, with the exception of emergencies.

_____ _____
Patient (or Guardian) Signature Date

_____
Print name

PATIENT COMMUNICATION AUTHORIZATION

Dr. Hess may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. Contact may also be made through email, or mail. By signing this form, you are giving Dr. Hess or her agents, authorization to contact you.

_____ initials

BILLING INVOICES

Providing your email address here indicates your acceptance with being emailed invoices for any balances due. If you do not provide your email address invoices will be mailed to you.

_____
Email address

MEDICAL RECORDS ACCESS AND RELEASE OF INFORMATION

In conjunction with my care with Jennifer Hess, DC, there may be additional records, imaging and imaging reports, lab results, and related medical records that will be of assistance in correlating my treatment. **I agree to allow Jennifer Hess, DC access to those pertinent medical records.** Any authorization I provide regarding the use and disclosure of my health information may be revoked at any time *in writing*. After I revoke I authorization, Hess Chiropractic will no longer use or disclose my information I for the reasons described in the authorization.

Also, I hereby authorize Jennifer Hess, DC to furnish to my insurance company, employer, other payer or their special representatives, any and all information required to process my claims. I understand that Jennifer Hess, DC will obtain special permission if it is necessary to release information related to treatment for drug/alcohol abuse, mental health or HIV related conditions.

By initialing this section I acknowledge that I understand that I am giving access to my personal medial records. A copy of this authorization is as valid as an original.

_____ initials