connect
CHIROPRACTIC
& WELLNESS

Sivan Dirks L.Ac
3821 NE MLK Blvd.
Portland, OR 97212 Ph~503-954-660

Consent to Treatment

I agree to Acupuncture and services included therein. I understand that results are not guaranteed. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to discontinue participation in these procedures at any time. I do not expect the physician to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my practitioner to exercise judgment during the course of treatment which she thinks at the time, based upon the facts then known, is in my best interest. With this knowledge, I voluntarily consent to treatment, realizing that no guarantees have been given to me regarding cure or improvement.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Insurance & Financial Policies

Insurance Billing: If you have health insurance, please understand that this is an agreement between you and your insurance company and **you are responsible for knowing your benefits** and **are ultimately responsible for timely payment for any services that you receive at our facilities.** Co-pays and Co-insurance are due at the time of service. **Please check with your insurance company to find out if there are any exclusions in your policy.**
In the event of a Motor Vehicle Accident/Worker's Compensation Claim, we will submit your claim(s) to the respective insurer, **but you will be responsible for any costs that they do not pay.** ***Initial here*** _____
It is the patient's responsibility to pay for visits and procedures not paid by insurance within a usual and customary time frame (60-90 days). **Please be aware of your coverage, as you are ultimately responsible for the cost of services rendered.** ***Initial here*** _____

Cash Pay: As a courtesy, patients may receive a "Paid at Time of Service" discount for any services paid in full at time of service. **This discount will not apply to laboratory tests, medicinary/supplement or retail items**. We accept cash, credit cards and personal checks. **Your account must be paid in full at the time of service**. If you present a check to *Dr. Rachel Eppinga or Connect* that is not honored by your Bank, a **$30.00** Non-Sufficient Funds charge will be added to your account per occurrence. This must be paid in full before any future services will be rendered ***Initial here*** _____

Late Cancellation/Missed Appointments: If you are unable to keep an appointment, you must cancel within 24 hours prior by calling the office at: (503)-954-1660.
There will be a minimum charge of $45.00 for all no-show and/or appointment cancellations with LESS than 24 hours notice. If you are scheduled for a consult and Acupuncture on one day, this is considered two appointments as two visits have been reserved on the schedule. Please note that appointment reminders are a courtesy. **If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies.** ***Initial here*** _____

Authorizations:
I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage. ***Initial here*** _____
I authorize the release of any medical or other information necessary to process any claims. ***Initial here*** _____
I authorize payment of benefits to Dr. Rachel Eppinga for all services rendered. ***Initial here*** _____

Patient's or Authorized Person's Signature:

Name (please print):_____ Signature:_____ Date: _____