# Hands On Health Care

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## Privacy Practices:

I acknowledge having viewed or received a copy of the Notice of Privacy Practices.

Patient Name (please print): _____

Signature: _____ Date: _____
Relationship to Patient (if other than self): _____

*Note: If this acknowledgement is being signed by a patient's legal representative, you must provide a copy of power of attorney or other relevant document(s) designating you as the legal representative.*

## Office Policies: (please initial and sign at the bottom)

_____I hereby authorize Hands on Health Care to furnish the Insured's Insurance Company all information pertaining to my case to assist me in making collections. Any amount received from said Insurance Company will be credited to my account. I hereby assign to the Doctor all money to which I am entitled for expenses relative to the services performed from time to time.

_____I agree that I am financially responsible to Hands on Health Care for any charges not covered by my Insurance Company. If I am uninsured, I agree that I will pay all charges incurred **at the time of service**.

_____I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If Hands On Health Care does not receive such payments, I understand I will be sent to a collection agency.

_____I understand that if I have missed my appointment or failed to cancel my appointment without 12 hours notice, I will be charged the price of services scheduled for that day.

_____I hereby authorize Dr. LeGat and/or other licensed doctors of chiropractic who now or in the future work at Hands on Health Care to examine and treat my condition as is necessary, through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

_____I understand that an office visit consists of a spinal manipulation only. Other charges might include electric stimulation, ice/heat, ultrasound, or Active Release Technique. Dr. LeGat and/or other licensed doctors of chiropractic who now or in the future work at Hands on Health Care will determine the treatment needed during the office visit. You are welcome to inquire about any possible extra charges **before** treatment and decline receiving these therapies.

I have read the above statement and agree to these terms.

Signature: _____ Date: _____