Coastal Spine and Rehab Center

Dr. Theresa Crandall, Chiropractic Physician

Financial and Office Policies

At Coastal Spine and Rehab Center we are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial and Office Policies are important to our professional relationship. Please ask if you have any questions about our fees or our Office Policy.

Insurance Coverage:
Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)
A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance (please initial)
C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

* All patients **MUST** complete our Patient Information forms completely prior to seeing the doctor.

* Payment in full is due at the time of service.

* Please discuss any scheduling or financial matters with the front desk personnel.

* We accept cash, checks and credit cards – Visa and MasterCard

* RETURNED CHECKS: There is a service charge of $25.00 for any returned checks.

ALLERGIES: Please list any and all allergies you may have on our Patient Intake Form as well as discuss them with the doctor. Many of our patients suffer from allergies. Please do not wear any scents to our office. This includes perfume, cologne or strong scented body lotions or powder. We thank you in advance for this courtesy to our other patients.

PACEMAKERS, SURGICAL IMPLANTS, KNEE and HIP RELACEMENTS: Please list any and all of the aforementioned items in your Patient Intake form as well as inform the doctor on your first visit. Some of our therapy modalities are contraindicated for these conditions.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL AND OFFICE POLICIES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. By signing below, I understand and agree to the conditions of this policy.

_____ _____

Signature Date

13910 Fivay Road, Suite 10, Hudson, FL 34667 Pho: 727-862-3509 Fax: 727-862-3500

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Dr. Theresa Crandall, Chiropractic Physician

Informed Consent

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulation treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby giv my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE.

_____

Printed Name of Patient

X_____ _____

Signature of Patient Date

X_____ _____

Signature of Representative Date
(if patient is a minor or is handicapped)

X_____ _____

Witness to Patient's Signature Date

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