Patient Name:_____ Date of Birth:_____

Consent and Conditions of Service

As either the Patient or the legally authorized representative of the patient on behalf of the patient receiving care with Stephanie A. Hoglund, DC, I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient, in partial consideration of health care services to be provided to the Patient in the facility:

Consent for Services: I hereby give consent to Stephanie A. Hoglund, DC to perform Chiropractic adjustments and/or Acupuncture and any other chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, spinal decompression and/or cold laser therapy on me (or on the patient named for which I am legally responsible) which are recommended as treatment for me. I have the opportunity to discuss with the doctor, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment, including but not limited to, fracture, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no improvement of symptoms. I do expect the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Release of Information: Stephanie A. Hoglund, DC is required by law to make and keep records of the Patient's medical treatment. The Chiropractic Physician safeguards those records and uses and discloses such records and the information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Physicians Notice of Privacy, which may be amended from time to time. I understand that the Patient may ask for a copy off the current notice at any time.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payers that are payable to the Patient or on behalf of the Patient for health care, services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the Physician for the exclusive purpose of paying for charges associated with the health care services provided to the Patient by the Physician. I understand and intend that all insurance companies and other third party payers will pay benefits directly to the Physician in payment of the Physician's charges and the charges of any other health care providers for whom the Physician is authorized to bill in connection with health care services provided to the Patient.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to the Patient by the Physician including but not limited to any amounts not paid by any insurance company or other third party payer (excluding a contract discount). Patient and the undersigned, if other than the Patient, remain responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payer. I understand and agree that a finance charge of 1.5% per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay a collection fee of up to 40% and all legal fees of collection with or without suit, including attorney fees and court costs.
A service charge of $20.00 may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to the Physician.

Missed Appointment Policy: A 24-hour notice is required for all cancellations. A $40 fee will be charged for all missed appointments. Your group, auto, or personal insurance will not cover this fee. If the office is closed, please leave a detailed message.

Photo and Testimonial Release: Active Family Chiropractic is proud of the success that our patients experience and like to share our patient's progress with others from time to time via our Facebook page, website and other media. If the opportunity arises we would like to share your photo, success story, and/or testimonial with others to help spread the word about the benefits of chiropractic care and how we can help the lives of others. Please choose an option below:

☐ Yes, I give permission for Active Family Chiropractic to use **my photo** and testimonial to be shared on Facebook or Instagram or the Active Family website.
☐ Yes, I give permission for Active Family Chiropractic to use my testimonial to be shared on Facebook or Instagram or the Active Family website, **but not my photo.**
☐ I do not give my permission for my information to be shared on the website or Facebook.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I many have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing.

_____ _____
Signature Date

_____ _____
Witness to Signature Date

I hereby acknowledge that I have received or have been offered a copy of the Notice of Privacy: Date_____Initials:_____