

# WELLNESS WAY CHIROPRACTIC

Dr. Karen Feeley

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## Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain it. This will prevent any confusion.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. By signing below, you choose to accept chiropractic care on this basis.

## Office Financial Policy

If you have insurance, present your insurance card(s) to the receptionist. A copy will be made for our records. We will contact your insurance company and inform you of your benefits. This will be reviewed with you at your next appointment. Our office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

As a courtesy, we accept most insurances, but it should be mentioned that you are ultimately responsible for all charges incurred during your treatment. We will submit charges to your insurer; however, we are not mediators between you and your insurance company, and we will not enter into any dispute with same. We promise to do our best to keep you informed of any issues that affect you financially.

By signing below, you are authorizing the release of any medical or other identifying information necessary to process insurance claims for reimbursement. You are also requesting payment of government benefits either to yourself or to the party who accepts assignment. If assigned, you authorize payment of medical benefits to the physician or supplier for services rendered.

The information we receive from you is used for identification and insurance purposes. We will not disclose any information about you or your personal history without your prior written authorization. You are giving us permission to be able to leave messages at the phone numbers you have provided for scheduling reasons only.

I agree to allow this office to examine me for further evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_