Arapahoe Alternative Health Care Services, Inc.
6881 S. Holly Circle, Suite 207
Centennial, CO 80112
303-221-3600

CHIROPRACTIC FINANCIAL POLICY / INFORMED CONSENT

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any examinations, diagnostic testing, or treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

WE OFFER A DISCOUNT FOR SENIORS AND FULL PAYMENT AT TIME OF SERVICE.

X-RAYS COMPLETED IN THE OFFICE ARE THE PROPERTY OF THIS OFFICE. PHOTOCOPIES OF X-RAYS MAY BE OBTAINED FOR A SMALL FEE.

A CANCELLATION FEE MAY BE ASSESSED IF YOU FAIL TO CONTACT THE OFFICE WITHIN 12 HOURS OF YOUR APPOINTMENT TIME.

REGARDING INSURANCE:

Your insurance policy is a contract between you and your insurance company. We will accept assignment of insurance once chiropractic benefits have been verified with your insurance carrier. Full payment of deductibles and co-payments are due at the time services are rendered. **ANY REMAINING BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT.** Please be aware that some of the services provided may be non-covered services under the Medicare Program and/or other Medical insurance. Returned checks and balances older than 45 days are subject to all costs of collections and legal fees.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, except in cases of provider discounts where our office is a preferred provider. Finance charges of 1% per month will be applied to all balances outstanding for more than 30 days.

INFORMED CONSENT:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, acupuncture, massage therapy, and diagnostic x-rays and laboratory tests, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctors, physical therapist, acupuncturist, nutrition therapist, or massage therapist who now or in the future treat me while employed by, working or associated with A.A.H.C.S.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise judgment during the course of the procedure which the practitioner feels at the time, based upon the facts then known, is in my best interests.
I have had an opportunity to ask questions about this content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Thank you for reading our Financial Policy / Informed Consent. Please let us know if you have any questions.

I have read and agree to this Financial Policy / Informed Consent:

X____ Date____________________
Signature of Responsible Party