



PATIENT/DOCTOR AGREEMENT

Our Goal: You, the patient have come for help from Dr. Clem. We have scheduled a health history consultation and exam for Dr. Clem to be able to assess your health problems and how to help you in pursuing better health. We have seen as patients begin to fully understand what is required during this treatment, the results are amazing.

The following policy information sheet exist in creating/ clarifying your financial agreement and explaining your insurance billing requirements, to make billing needs as smooth as possible.

Services Available:

- *New Patient Consult/Exams
- *Report Of Findings
- *Extremity Adjustments
- *Nutrition Consultations
- *Progress Evaluations
- *X-Rays
- *Spinal Adjustments
- *Therapeutic Procedures
- *Orthotics-Custom Made Foot Orthotics
- *Supplements

You will be charged for the appropriate services. There can be discounts given with cash accounts in custom made affordable plans. If you have chiropractic, insurance that the doctor participates with, we will bill them for you. Today's visit does not include or imply obligation for chiropractic care. If we bill you for services rendered there will be an accompanying finance charge. There is a \$25 NSF Charge for all returned checks.

_____ Initials

Assignment/Direct Payment to Doctor: For Private and Group Accident/Health Insurance.

I hereby instruct and direct the _____ Insurance Company to pay by check and mail directly to:

DISCOVERY WELLNESS CENTER/Nathan Clem, D.C., 3655 34TH Ave. West Seattle, WA 98199

If my current policy prohibits payment to doctor, then I hereby also, instruct and direct you to make the check out to me and mail it to the above address, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

_____ Initials

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY:

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

_____ Initials

MISSED/CHANGING CHIROPRACTIC & MASSAGE APPOINTMENTS

We will set aside time for chiropractic and/or massage appointment for you to receive treatment with the Doctor and/or Massage Therapist. If for any reason you may be unable to keep your scheduled appointment, you must give a 2 hours notice for chiropractic appointments or be charged to you the personal service charge of \$35.00. If for any reason you may be unable to keep your massage scheduled appointment, you must give a 24 hours notice or be charged to you the personal service charge of \$65.00.

_____ Initials

By signing below, I indicate that I have read the above policies and agree to the applicable conditions.

Print Patient Name

Patient Signature

Today's Date