TWO HANDS CHIROPRACTIC & ACUPUNCTURE, PLLC
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MEDICAL CONSENT FORM

I authorize Two Hands Chiropractic and Acupuncture, PLLC to examine and treat me for my complaints, injuries and illness. Treatments, as well as risk and benefits of treatments, will be explained prior to administration.

I understand that although complications associated with chiropractic care are rare, some potential risks include fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown to the doctor. I further understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations or joint restrictions allowing the body to return to improved health.

I understand that although complications related to acupuncture are rare, some potential risks include slight pain or discomfort at the site of the needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment. I also understand that the potential benefits include relief of one's symptoms.

Treatments performed at Two Hands Chiropractic and Acupuncture, PLLC will be administered by Dr. Shanna Fritsch, Board Certified Chiropractic Internist and Illinois Licensed Chiropractic Physician with Acupuncture Certification.

I understand and I am informed that, as is true with all health care treatments, results are not guaranteed and there is no promise to cure.

GOOD FAITH ESTIMATE

Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.
•You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
•Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
•If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
•Make sure to save a copy or picture of your Good Faith Estimate.
For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

HIPAA NOTICE OF PRIVACY PRACTICES

We keep medical records of the services we provide for you. You may ask to see a copy of your records. 48 hours' notice is required for copies of medical records. You may ask to correct your records. Your records will be kept confidential unless you give us written permission to release them or we are required to do so by law. We will ask you to sign a consent form allowing Two Hands Chiropractic and Acupuncture, PLLC to use and disclose your health information for the purpose of treatment, payment, and health care operations in this office.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your care. Your clear understanding of our Financial Policy is important to our professional relationship.

- Full payment is due at the time of service. We accept cash, check, and credit cards. We do not accept any insurance, except Medicare. We are non-participating with Medicare which means that Medicare patients will also need to pay the "allowed Medicare fee" for covered services on the day of service.
- All patients must complete our medical consent form and other related forms. We also require a copy of your photo ID. Medicare patients will also be required to give us a copy of their Medicare card.
- Accounts with no activity for 60 days (payment, payment plan implementation, etc.) may be sent to collections.
- There is a $40 service fee for all returned checks.

SUPPLEMENT RETURN POLICY

In the rare event that we order supplements or other medical supplies for you as a special order, and you reconsider, we will refund your money minus a 25% restocking fee.

CANCELLATION FEE POLICY

If it is necessary to reschedule your appointment, please provide us with 24-hour notice.

Otherwise, a fee of 50% of the scheduled appointment cost will be incurred.

RECEIPT OF CONSENT FORMS AND POLICIES

Upon receiving and reviewing these policies your initials are required below.

_____Medical Consent Form

_____Good Faith Estimate

_____HIPAA Notice of Privacy Practice

_____Financial Policy

_____Supplement Return Policy

_____Cancellation Fee Policy

I, _____ by signing below have received and read all of the above listed policies provided to me by Two Hands Chiropractic & Acupuncture, PLLC.

_____	_____	_____
Print Patient Name	Patient or Legal Guardian Signature	Date

_____	_____
Witness (Two Hands Staff Signature)	Date