Hoyer Chiropractic Clinic

Notice of Privacy Practices

Hoyer Chiropractic is dedicated to ensuring the privacy of your protected health information. We are required by law to provide you with a Notice of Privacy Practices, and to inform you of your rights, and our obligations, concerning your protected health information. By initialing, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of Hoyer Chiropractic.

Statement of Informed Consent

The State of Iowa requires every patient be informed of the risks of treatments prior to the beginning of care. We intend this consent to cover the entire course of treatment for your present condition and any conditions you seek treatment for at this clinic. As with any healthcare procedure, there are risks that exist. Dr. Hoyer and his staff make every effort possible to provide the safest chiropractic care available. We would be glad to explain any concerns about treatment you may have and would only recommend treatment for you that we would feel comfortable having performed on ourselves. I have read Hoyer Chiropractic's consent to chiropractic treatment. I understand that all treatments have risks and benefits. If the risks and benefits are not clear to me, I will request further information from the doctor.

Financial Policy

Payment is expected at the time of service. Your insurance company can and will be billed, determined by our current status as in-network or out-of-network with that company. We make every effort to determine your benefits and eligibility, but cannot guarantee your coverage. Final approval of coverage is based on the explanation of benefits after the claim has been filed. Any remaining balance is the responsibility of the patient. If payment is not made at the time of service, the patient is expected to remit payment within 30 days of receiving a billing statement. We would be happy to address any questions or concerns regarding your account at any time.

Assignment of Benefits

Assignment of benefits allows Hoyer Chiropractic to file charges directly to your insurance company. I authorize Hoyer Chiropractic to submit my insurance claims to my insurance company. I understand that I may withdraw my signature at any time. I understand that I am responsible for all charges for which my insurance does not pay.

Consent for Radiology

I give Dr. Hoyer my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards at this office.

**For Ladies only: To my best knowledge I am not pregnant and know of no contraindications of x-rays at this time.

Signature_____ Date_____