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## ***Secret Family Chiropractic, P.C (SFC)***

### ***General Office Policies for Patients***

#### **Confidentiality**

If an outside person or agency requests information concerning your case, we require their inquiry be in writing with a signed release form from you, the patient, before information may be disseminated. A charge may be made for the copy and handling of records. Your records here remain under lock & key.

#### **Your Rights**

You have the right to be treated with courtesy, respect and dignity.

You have the right to know the process through which services are offered, including the general course of treatment, whom you will be working with and what evaluations/testing of your progress will be made.

You have the right to obtain any nutritional supplements prescribed by your physician at other locations, if also provided by this office. We will try to supply you with sources where discounts may apply.

#### **Appointments**

We consider an appointment to be an agreement between you and our office. We are responsible to be here and provide our services, or to inform you otherwise. You are responsible for keeping the appointment or giving us 24 hours notice of cancellation. Should you decide not to keep the appointment without giving the appropriate notice, you may be billed a **\$25 service charge** unless the appointment can be filled by another patient in need. Naturally, we will make exceptions in case of an emergency.

#### **Self-Strengthening Therapy**

Since it is quite common for an insurance plan to limit the number of Chiropractic treatments, it is important that you make as much progress as possible in the time allotted. Therefore, your physician may recommend certain exercises or self-strengthening therapies be conducted both **at home** and during your office visit. **We strongly advise these therapies be carried out correctly and timely.** To not do so, may be cause you insurance carrier to limit or cancel care. SFC may also cancel care, due to non-compliance.

#### **Payment**

In order for us to keep our services available to our patients, it is necessary to require co-payments and deductible payments at the time of service. We accept most insurance payment schedules, after obtaining verification of coverage and benefits for chiropractic services. Since most verifications are verbal and time sensitive, you should be aware that actual insurance payments may vary from the initial verification, deductibles recorded by the insurance plan may not be accurate at time of verification, and some of our services may be limited in number or service type. In typical words of various insurance carriers, **"verification of benefits does not guarantee payment of those benefits."** In such cases, it shall be **your responsibility to pay those charges not covered by your insurance plan.** We will make every effort to advise you of such charges to your account on a timely basis. Late payment of invoices will be subject charges of 1 3/4% per month. Invoices beyond 90 days may be sent out for collection and delinquent patients will be responsible for all additional collection costs, including legal and court fees.

#### **Address and Insurance Change**

Please inform us of name, address, phone number, employment, marital status and insurance changes.

#### **Integrity Agreement**

Both parties desire to have a method of resolving discomfort, misunderstanding, or disputes. If any of the above occur, please bring them to our attention privately, quickly and in a friendly manner. Both parties agree to resolve these matter using communication, negotiation, mediation and arbitration procedures as set forth in the latest edition of the standard Law Forms Integrity Agreement (*This does not relinquish your right to seek legal council*).

#### **Assignment of Benefits**

I hereby assign my medical benefits for services rendered by SFC and request **payment be made directly to Secret Family Chiropractic, PC by my insurance carrier or attorney.** This assignment will remain in effect until I revoke it in writing. A photocopy or fax of this assignment is to be considered valid as an original. I authorize SFC to release all information necessary to secure payment in full. I understand that I am financially responsible for all the charges, whether or not paid by my insurance carrier or attorney.

Patient's Signature \_\_\_\_\_

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