ADVANCED SPINAL CARE, LLC

Dr. Amber Pergande, D.C.
1052 Oak Forest Dr., Suite 210
Onalaska, WI 54650
608.783.0384

RECEIPT OF PRIVACY NOTICE/OTHERS INVOLVED IN MY HEALTHCARE

Patient name _____

Date of birth _____

Patient No. _____

Telephone _____

You, Dr. Amber Pergande, D.C. ***MAY discuss*** all aspects of my healthcare with:

_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship

As the patient, you may also request that any part of your Private Health Information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You, Dr. Amber Pergande, D.C. ***MAY NOT*** discuss any aspect of my health care with the following person/people, unless it is needed to provide emergency treatment.

_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship

My signature, below, certifies I have received a copy of NOTICE OF PRIVACY PRACTICES.

_____	_____
Signature of Patient or Guardian	Date

(You have the right to rescind any part of this authorization with written notice.)

ADVANCED SPINAL CARE, LLC

Dr. Amber Pergande, D.C.
1052 Oak Forest Dr., Suite 210
Onalaska, WI 54650
608.783.0384

TERMS OF ACCEPTANCE

When a patient seeks upper cervical health care and we accept a patient for such care, it is essential for both parties to be working toward the same objective.

NUCCA care has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmary.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to treat any disease or condition other than Vertebral Subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct Vertebral Subluxation.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept upper cervical care on this basis.

_____
Patient/Guardian Signature

_____
Date

OUR FINANCIAL POLICY

1. We are a fee for service office. All patients are seen on a cash basis regardless of insurance coverage unless a Personal Injury, Auto, or Workers Compensation claim is open or being opened.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during the report of findings.
3. If you have insurance we will gladly provide you with the necessary paperwork and codes the insurance company will need to process the claim. We are not a mediator between you and your insurance company and will not enter into any dispute with them, as your contract is between you and your insurance company.
4. All patients (except Medicare) will send in their own claims to their respective insurance companies and will thus receive their payment directly.
5. Our office must submit Medicare claims directly. Patients are seen on a cash basis. Payments are due as services are rendered. Medicare patients will receive a check directly from Medicare.
6. Any services not covered or coverage reductions by the patient's insurance will be the patients responsibility.
7. If the patient is referred to another specialist or discontinues care for any reason, the bill is due and payable in full immediately.
8. In order to better serve our patients we ask that if you are unable to keep your appointment to kindly give 24 hours notice. We reserve the right to charge for time reserved.
9. If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

Thank you.

I have read and understand the Office Financial Policy and agree to abide by these terms.

_____
Patient/Guardian Signature

_____
Date