# OFFICE POLICIES OF CRABBE CHIROPRACTIC

**PERMISSION TO COMMUNICATE**

I authorize and give permission to Dr. Thomas Crabbe and his staff to communicate with me by regular mail, email, phone calls to my home, work, wireless phone or answering machine(s). I understand that communication will be in regards to appointments, clinical issues and clerical issues. I understand that due diligence will be employed in being discrete about any clinical issues conveyed via any of the above modes of communication. I understand that I have the right to refuse certain types of communication by notifying Dr. Thomas Crabbe or his staff in writing.

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

I hereby authorize Dr. Thomas Crabbe, or his assigned staff members, to release information contained in my medical records to any and all insurance carriers for whom I may be due benefits, to my primary care physician and other healthcare professionals associated with my treatment, to the state chiropractic society in the event their assistance is needed on my behalf, and to my attorney of record (if an attorney is involved).

**ASSIGNMENT OF BENEFITS**

I hereby instruct and direct that payments for my services be sent directly to Dr. Thomas Crabbe or the Crabbe Chiropractic office and not to me, my guardians, my estate, or my attorney, regardless of any assignments of benefits my attorney or others may present on my behalf, and regardless of the date of such other assignment or instruction may be signed by me or presented by others.

- I hereby instruct and direct that payments for health care provided me by Dr. Thomas Crabbe, as reflected in bills for such service that he may present, as maybe due me under terms of a contract of insurance, or as a result of an action at court, settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, be sent directly to Dr. Thomas Crabbe. The instruction shall be considered irrevocable, and shall survive me, and my period of care under Dr. Crabbe forever and without exception.
- Regarding only payment for Dr. Crabbe's services to me as reflected in bills he presents I hereby rescind any and all assignments of benefits presented by my attorney of any date prior to this date to any party receiving this notice.

Also, under all circumstances, I direct and instruct that any monies sent to any party as payment for the services at Crabbe Chiropractic, following receipt of office bills and or statements, BE MADE SOLELY TO DR. THOMAS CRABBE.

**COLLECTION POLICY AGREEMENT**

- I hereby acknowledge that I am ultimately fully responsible for the payment of all charges or fees for services provided me, regardless of any contract of insurance, any action at court, any settlement, structured settlement, verdict or arbitration award which I may receive or be due, or the course or outcome of any dispute regarding the same. I also understand that I may be charged a 1.5% monthly interest charge for any patient balances unpaid after 30 days.
- I agree to deliver to Dr. Crabbe any check, draft of funds that I may receive from any source intended as payment for services rendered me by Dr. Crabbe within 10 of receipt by me and to be responsible for a 1.5% month interest accrued for failure to deliver money after 30 days.
- I agree to reimburse Dr. Crabbe for all reasonable collection costs he incurs that arise from collection actions he takes against me in the process of settling my account.

## APPOINTMENT POLICY

**We reserve the right to charge a $30 fee for appointments that are blatantly missed or appointments that are cancelled without notice of at least four (4) hours. The $30 fee is your bill, not your insurance company's bill.**

I acknowledge that **1)** I received the HIPPA policies of this office and **2)** I have read, understand and agreed to the above office policies:

My Signature:________________________________Date:____________________