CHIROPRACTIC
Helping Build a Strong Foundation for Your Health

(503) 224-9513 www.citychiro.net
Jackson Tower ◻ 806 SW Broadway ◻ Suite 350 ◻ Portland, OR 97205

Larry M. Hanberg D.C., P.C.
Reyn M. Johnson, D.C.

Clinic Policies

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue of regaining and maintaining your health. We will gladly answer any questions you may have regarding our policies, your account or insurance coverage.

No Charge Consultation
City Chiropractic will do a special "no charge" consultation or brief conference with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no obligation in connection with this consultation and a **good faith estimate** is provided below.

Patient Payment Policy
We feel the patient's health needs are paramount. Therefore, the following payment policy is an attempt to allow you, the patient, the receive the care you need and clear your balance with the least amount of difficulty.

Good Faith Estimate - Fee Disclosure Notice

Patient/Doctor Consultation	No Charge
New Patient Initial Examination	$100-300
Established Patient Examination	$60-200
X-Rays (per view)	$33-45
Basic Office Visit (Adjustment)	$35-80
Heat/Cold Therapy	$20-30
Exercise Instruction	$20-50
Modalities/Therapies	$20-50
Supplements/Supplies	$10-75

This is only an estimate. Actual services and charges may differ.

New Patient Care Services
All patients with or without insurance are responsible for full payment on the first visit unless other arrangements have been made in advance. Properly documented Worker's Compensation and Auto Accident claims are not required to pay at this time if the appropriate forms and liens are signed and PIP benefits are confirmed.

Today's Payment Will Be Made By (please check one):
◻ Cash
◻ Check
◻ VISA, MasterCard or American Express

Established Patient Care Services
All patients under care will have a financial consultation to discuss and arrange their specific payment options and/or arrangements.

Our Policy on Health Insurance
Today many insurance policies do cover chiropractic care. We will be glad to file your primary insurance claim for you and do everything we can to assure you receive proper reimbursement. Though we do bill as a courtesy, we cannot take responsibility for what your health insurance will or will not cover.

Appointments
In order to better serve our patients, we ask that you call, text or email if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others.

Emergency or After Hours Calls
In case of an emergency you may contact the office for a special appointment any time during regular office hours. If you, a friend, or family member requires assistance after hours or on a weekend, please call other emergency services such as 911, for assistance.

Questions and Answers
All questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer any inquires.

I have read the City Chiropractic policies and will honor them.

Patient Signature: _____ Date: _____

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Welcome

We would like to take this opportunity to welcome you to our clinic. You will notice that our clinic is different, in a positive way. We have a healing environment that is enjoyable and you will find our staff considerate and helpful. We will do our utmost to make your overall experience in our clinic an excellent one in every aspect.

Furthermore, we strongly believe in educating our patients so they completely understand and get the greatest results with their care. Over the next few visits you will see a couple of short videos, be provided educational material, and we will even quiz you (easy ones).

So even if you have been to other Chiropractors before, please follow through with our procedures. Our office is unique and we are certain if you remain open minded that we will be able to teach you some amazing new information that you did not know.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has one primary 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method of correction is by specific adjustment to the spine, sacrum, pelvis and extremities.

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

Subluxation: A misalignment of one or more of the vertebra in the spinal column, sacrum, pelvis and/or extremity joints of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease (heart disease, cancer, diabetes, etc.) or condition other than musculoskeletal related disorders. 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 another health care provider.

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 help maximize your health potential.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care in this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(signature) (date)