Dr. Adam J. Lukes, DC | Dr. Amanda L. Lukes, DC

3620 Bemidji Ave N. Bemidji, MN 56601

Phone: 218-751-4936 Fax: 218-444-2480

NON-COVERED SERVICES CONSENT

I understand that some services may not be considered eligible benefits (e.g., services and/or supplies may be determined to not be medically necessary, non-covered or investigational) by my health insurance provider. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services. Examples of these non-covered items include, but are not limited to: exam(s), adjustment(s), traction, ultrasound, cold laser therapy, myofascial release/Graston, durable medical equipment, supplements, and/or nutrition consultations.

Service	Cost
Consultation/Exam	$30-73
Therapies: Ultrasound, MFR/Graston, Cold Laser, Traction	$18-26
Non-Spinal Adjustment (Extremity)	$30-36
Maintenance Care Adjustments	$40
Therapeutic Exercise	$14-36
Rock Tape	$5-20
DME: Supports, Pillows	$2-70
Emergency Office Call	$75

I UNDERSTAND THAT I AM AGREEING TO BE FINANCIALLY RESPONSIBLE FOR ANY AND ALL RELATED CHARGES IF THEY ARE NOT COVERED BY MY HEALTH INSURANCE.

★ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY ______________________________ DATE ______________

HIPAA PRIVACY POLICY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Lukes Chiropractic and Wellness (Dr. Amanda L. Lukes, and Dr. Adam J. Lukes). Which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices. (Copy available to review or keep upon request).

PATIENT'S NAME (Print)______________________________ DATE OF BIRTH______________

★PATIENT OR GUARDIAN SIGNATURE ______________________________ DATE______________

PAYMENT POLICY

Thank you for choosing Lukes Chiropractic and Wellness as your chiropractic provider. We are committed to providing you with quality and affordable health care. ***Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered we ask that you please read our payment policy, ask any questions you may have, and sign in the space provided below.*** A copy will be provided to you upon request.

1. SELF PAY. I am choosing **not to have my visits submitted to my insurance** and **pay for each visit out of pocket**. All charges will be my responsibility. ★ Self-pay, please initial here: ___________

2. MISSED APPOINTMENTS/LAST MINUTE CANCELLATIONS. Our office policy is to charge a fee of $35.00 per patient after two missed appointments and/or last-minute cancellations (*less than 2 hours notice - for family blocks of 3 or more people, we require at least 24 hours' notice for cancellations.*) This fee will apply to any future missed appointments or late cancellations. **All charges will be your responsibility and billed directly to you.** We will also require that any further appointments be scheduled on the same day that you call in to the clinic. We appreciate your cooperation in notifying us at least 2 hours (or 24-hrs for family blocks) in advance if you are unable to attend your appointment(s)**.**

3. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits **is your responsibility**, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral from your primary care physician prior to your first visit.

4. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

5. PROOF OF INSURANCE. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of any claims.

6. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

7. COVERAGE CHANGES. If your insurance coverage changes, please notify us **before** your next visit. If we are not made aware of this change in a timely manner you will be **responsible for services rendered or you will not be seen until current insurance is obtained**. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

8. FINANCE CHARGE. A $10.00 finance charge will be added to your account if payment is not received within 30 days of statement. If payment is not received within 60 days of initial statement you will have 10 days to pay before your account is sent to collections with 30% interest added.

I HAVE READ AND UNDERSTOOD THE PAYMENT POLICY AND AGREE TO ABIDE BY THE GUIDELINES.

★ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY ____

DATE ____________________

CHIROPRACTIC INFORMED CONSENT

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustments are extremely rare.
Following are the known risks:

Temporary soreness or increased symptoms of pain. It is not uncommon for patients to experience temporary soreness or increased symptoms during or after your care.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify your chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risks of fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care, it is important to notify your chiropractor if symptoms change or worsen.

Stroke. A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during the stroke.

Other risks associated with chiropractic treatment include*:* Rare burns from physiotherapy devices that produce heat. Instrument-Assisted Soft Tissue Manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.
I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

PATIENT'S NAME (Print)____ DATE OF BIRTH_______________

★PATIENT OR GUARDIAN SIGNATURE ___________________________________ DATE_______________

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