THE NATURAL HEALTH IMPROVEMENT CENTER ST. JOSEPH

Dr. Katie Stull • Wellness, Chiropractic & Nutrition Response Testing
2820 Niles Rd. • St. Joseph, MI 49085 • 269-556-9615• nhicstjoseph.com

1. PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____________________________________ Date__________________

Signature___________________________________DOB_________________

2. SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize release of information to all of my Insurance Companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
I authorize payment direct to my doctor.
I permit a copy of this authorization to be used in place of the original.

Name___________________________________Date______________

Signature____

3. CANCELLATION POLICY FOR CHIROPRACTIC

My business as your Chiropractor is to help you, my patient, in the most efficient way possible. This business is a service. As a business, I want to serve you promptly and efficiently. Therefore, it is imperative to show up for your appointments as scheduled and on time. The following policies were developed to support this goal. THANK YOU

*Please contact the office at lease 4 hours in advance to cancel an appointment.

*If you have a massage, PLEASE CALL TO CANCEL 24 HOURS prior to your appointment. This policy applies for both cash and insurance massages. We will not charge you for your first missed massage appointment, after this we will charge you for the missed appointment.

I have read the policies and I agree to comply with the regulations as stated.

Signature____