_____
Initials

Hamilton County Chiropractic

AUTHORIZATION AND RELEASE:

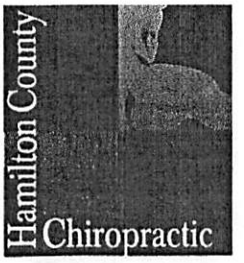
I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by the treating doctor, any fees for professional services will be immediately due. Discounts or coupons are not refundable. I understand that if my account becomes over 90 days delinquent that I will be responsible for any and all collection fees, legal fees, court costs, and a monthly interest rate of 20% of the account balance.

_____ _____

Patient Signature Date

_____

Printed Name



Initials

Hamilton County Chiropractic

Patient Policy & Procedures

1. We are here to help get the results you need and want by helping you stay on the doctor's recommended care plan.
2. We will pre-schedule your appointments. The front desk will help you find the days and times that are best for you.
3. Should you miss an appointment, it is our policy that the appointment is made up within seven (7) days to avoid a $25 no-show fee. We will do everything we can to get you rescheduled, and it is our policy to help you stick to your schedule and get the results you deserve.
4. If you are going to miss an appointment, or simply need to change an appointment, please notify us 24 hours in advance via phone or email to avoid the $25 no-show fee.
5. We will be performing regular re-exams to monitor your level of progress and correction.
6. If you have any questions, please ask. We are always here for you.
7. Our mission is to help you achieve and optimize your health.

Our phone number: (317) 776-1061
Front Desk Email Address: jacki@hamiltoncountychiro.com

I fully understand and accept Hamilton County Chiropractic's Policy & Procedures:

_____ _____

Patient Signature Date

Brookside Radiology Consultants, Inc. P.O. Box 349 Buzzards Bay, MA 02532 Ph: 508-743-5691 Fax: 774-302-4713

Patient's Name: _____ Age: _____ Sex: M / F

Referring Doctor: _____ Date of Films: _____ Date of Injury: _____

Chief Complain/Clinical Concern: _____

Diagnosis Code(s) _____ Previous Diagnosis, Surgery, Trauma, Cancer DOB: _____

BILLING OPTIONS: (X) Time of Service (TOS) Discount - Payment Must Be Enclosed For Discount (Credit Card or Check)

( ) INSURANCE Billing – Assumes Referring Doctor Billed "-TC" Only ( ) Bill Doctor (If Referring Doctor Bills Globally)

Card Type: _____ Card #: _____ Expiration Date: _____ V- Code: _____

Submit Copy of Insurance Card / Documentation OR Complete the Following

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Date of Birth: ____/____/____ SS #: _____

Insured's Name: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Relationship to Patient ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Primary Insurance Company: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

Policy #: _____ Claim /ID#: _____ Group/Plan #: _____

Secondary Insurance Company: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

Policy #: _____ Claim/ID #: _____ Group/Plan:#: _____

( ) Accident Related to Employment? Insured's Employer: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

( ) Personal Injury? ( ) Automobile Accident? Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

Patient X-Ray Assignment Agreement and Consent

I understand that this office will have my X-Rays interpreted by John R. Henry DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology. I am aware that I will be responsible for this service and accordingly I hereby authorize Brookside Radiology Consultants, Inc. (BRC, Inc.) assignment of benefits for services rendered directly from my insurance carrier or attorney. Therefore, I authorize BRC, Inc. to obtain information necessary to secure payment of benefits and authorize the use of this signature on associated benefit submissions. I also authorize the release of any medical information necessary to process the claim. Any amounts owed but not allowed will be my responsibility. Furthermore, I acknowledge that I have reviewed, with my doctor, and understand and agree to the Notice of Privacy Practices of BRC, Inc.

This Service is Not Covered by Medicare

Patient's/Guardian's Signature: _____ Date: _____

x	CPT	DESCRIPTION	FEE
	72040-26	Cervical 2-3v	$20.00
	72050-26	Cervical 4v	$24.00
	72052-26	Cervical 6-7v	$26.00
	72070-26	Thoracic 2v	$20.00
	72100-26	Lumbar 2v	$20.00
	72110-26	Lumbar 4-5v	$24.00

x	CPT	DESCRIPTION	FEE
	73030-26	Shoulder 2v	$20.00
	73080-26	Elbow 2-4v	$20.00
	73100-26	Wrist 2-4v	$20.00
	73120-26	Hand 2-3v	$20.00
	73510-26	Hip Unl 2v	$20.00
	73560-26	Knee 2v	$20.00

x	CPT	DESCRIPTION	FEE
	73600-26	Ankle 2v	$20.00
	71010-26	Chest 1v	$20.00
	71020-26	Chest 2v	$20.00
	71101-26	Ribs 2-3v	$20.00
	72010-26	Full Spine	$50.00
	72148-26	MRI Over Read	$20.00