Kirstin Ebaugh, DC * 1907 Garden Ave., # 102, Eugene, OR 97401 * 541.321.5700 * www.wholehealthchiro.net

**FINANCIAL/PAYMENT AGREEMENT**

I understand that I am responsible for the costs of chiropractic care, regardless of insurance coverage, including the deductibles, co-insurance, co-payments and non-covered services. Kirstin Ebaugh is a participating or preferred provider with many health insurance plans. However, plan participation and benefits vary and are subject to change and may ***not*** cover all provided services. A quote of benefits to Dr. Ebaugh by an insurance company is **NOT** a guarantee of payment or coverage. I understand that it will be **MY** responsibility to verify with my insurance carrier the plan participation status of Dr. Ebaugh and covered benefits prior to service being rendered. Insurance will be billed according to the billing/payment guidelines of my insurance. However, **ALL** charges will be my responsibility if services are not paid by my policy for any reason (such as if my benefit limits have been reached or misquotations of benefits).

I understand that if I suspend or terminate my schedule of care as determined by Dr. Ebaugh, any fees for professional services will be immediately due and payable. I also understand that I may be billed a fee of $25 for missed appointments that are not canceled 24 hours in advance, with the exception of emergencies.

_____ _____

Patient (or Guardian) Signature Date

_____

Print name

**PATIENT COMMUNICATION AUTHORIZATION**

Dr. Ebaugh may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine. Contact may also be made through email, text message, or mail. By signing this form, you are giving Dr. Ebaugh or her agents, authorization to contact you.

_____ _____

Patient (or Guardian) Signature Date

_____

Print name

**MEDICAL RECORDS ACCESS AND RELEASE OF INFORMATION**

In conjunction with my care with Kirstin Ebaugh, DC, there may be additional records such as imaging and imaging reports, lab results, and related medical records that may be requested to assist in my treatment with Dr. Ebaugh. **I agree to allow Kirstin Ebaugh, DC access to those pertinent medical records.** Any authorization I provide regarding the use and disclosure of my health information may be revoked at any time ***in writing***. After I revoke authorization, Whole Health Chiropractic will no longer use or disclose my information for the reasons described in the authorization.

Also, I hereby authorize Kirstin Ebaugh, DC to furnish to my insurance company, employer, when in conjunction with a worker's compensation claim, and any other payer (such as an HSA or flex spending account) or their special representatives, any and all information required to process my claims. I understand that Kirstin Ebaugh, DC will obtain special permission if it is necessary to release information related to treatment for drug/alcohol abuse, mental health or HIV related conditions.

By signing this section, I acknowledge that I understand that I am giving access to my personal medical records. A copy of this authorization is as valid as an original.

_____ _____

Patient (or Guardian) Signature Date

_____

Print name