Khoury Chiropractic, Inc.

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information.*

Patient Name Printed _____ Date _____

Patient Signature _____

Witness Name Printed _____ Date _____

Witness Signature _____

Our purpose at Khoury Chiropractic Inc. is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education. Insurance regulations prohibit us from discounting or negotiating co-pays, co-insurances, deductibles, and other fees and charges. All fees for services are payable at the time they are rendered. We accept cash, checks, Visa, MasterCard, etc... Verification of your benefits prior to your visit is your responsibility and is not a guarantee of payment, the patient is responsible for all bills incurred at this office.

We will bill your insurance company for their portion of the bill if we are in their provider network. All patients are expected to supply this office with any and all information necessary to file and bill your claims. If claims are denied due to lack of insurance coverage for any reason, payment of any balance is the responsibility of the patient. Please note that insurance companies will only provide reimbursement for services which they deem medically necessary and will not provide coverage for treatment that is considered wellness care, maintenance care, or for chronic conditions. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

I hereby authorize the Doctor to examine and diagnose my condition as he or she deems appropriate.

Patient Signature _____ Date _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Confidential Patient Health Record

PERSONAL HISTORY

Name: _____ Date of Birth: _____ Age: ____ Sex: □ M □ F

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

Home Phone: _____ Cell Phone: _____

Height: _____ Weight: _____ Race: _____ Ethnicity: _____

Employer: _____ (Circle one)

Type of Work: _____ Single Married Widowed Divorced Separated

Email: _____ Name of Emergency Contact: _____

Referred to this office by: _____ Phone number of emergency contact: _____

CURRENT HEALTH CONDITION

Reason for visit: _____

When did this condition begin? _____ Has the condition occurred before? □ Yes □ No

Other doctors seen for this condition: □ Yes □ No If yes, who? _____

Type of treatment: _____ Results: _____

Previous chiropractic care: □ None □ Doctor's name & date of last visit: _____

Name of Primary Care Physician (PCP): _____

PCP address: _____

Please list your current medications, dosage, date started, and prescribing doctor.

_____

_____

Please list any surgeries that you have had. Please include date and result of surgery.

_____

_____

Please list any diagnoses that you have received. Please include date of diagnosis.

_____

_____

Have you had any tests in the last year (lab, x-ray, MRI etc)? Please list test and result.

_____

_____

Immediate Family History – Please list family member & condition:

Relationship	Disease(s) or condition(s)	Deceased?		Cause of death
		□ Yes	□ No	
		□ Yes	□ No	
		□ Yes	□ No	
		□ Yes	□ No	

Do you smoke? □ Yes □ No If yes, how often: _____ Do you drink coffee? □ Yes □ No If yes, how often: _____

Do you drink alcohol? □ Yes □ No If yes, how often: _____ Do you wear a shoe lift/orthotics? □ Yes □ No

Do you use drugs? □ none □ recreationally □ addicted Do you exercise? □ Yes □ No If yes, how often: _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please check the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension) □ Yes □ No
  2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
  3. Diabetes □ Yes □ No
  4. Heart or blood vessel diseases □ Yes □ No
  5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
  6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
  7. Have any of your relatives suffered a stroke? □ Yes □ No
  8. Were you ever a smoker? If yes, from _____ to _____ □ Yes □ No
  9. Do you take any medications on a regular basis? □ Yes □ No
     - You will be asked to list these on page 3
  10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
      - If yes, from _____ to _____

- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision □ Yes □ No
  2. Double Vision □ Yes □ No
  3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
  4. Complete loss of vision in one or both eyes? □ Yes □ No
  5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
  6. Hearing loss in one or both ears? □ Yes □ No
  7. Slurred speech or other speech problems? □ Yes □ No
  8. Difficulty swallowing? □ Yes □ No
  9. Dizziness? □ Yes □ No
  10. Temporary lack of understanding? □ Yes □ No
  11. Loss on consciousness, even momentary blackouts? □ Yes □ No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
  13. Any other abnormal sensations in any part of your body? □ Yes □ No
  14. Weakness, clumsiness, or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
  15. Sudden collapse without loss of consciousness? □ Yes □ No

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Below is a list of diseases which may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD and **write in approximately when**:

- ☐ **Pneumonia**
- ☐ **Rheumatic Fever**
- ☐ **Polio**
- ☐ **Tuberculosis**
- ☐ **Whooping Cough**
- ☐ **Anemia**
- ☐ **Measles**
- ☐ **Mumps**
- ☐ **Smallpox**
- ☐ **Chicken Pox**
- ☐ **Diabetes**
- ☐ **Cancer**
- ☐ **Heart Disease**
- ☐ **Thyroid**
- ☐ **Influenza**
- ☐ **Pleurisy**
- ☐ **Arthritis**
- ☐ **Epilepsy**
- ☐ **Mental Disorders**
- ☐ **Lumbago**
- ☐ **Eczema**

Have you been tested HIV Positive? ☐ **Yes** ☐ **No**

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE
- ☐ **Low Back Pain**
- ☐ **Pain Between Shoulders**
- ☐ **Neck Pain**
- ☐ **Arm Pain**
- ☐ **Joint Pain/Stiffness**
- ☐ **Walking Problems**
- ☐ **Difficult Chewing/Clicking Jaw**
- ☐ **General Stiffness**
- ☐ **Gas/Bloating After Meals**
- ☐ **Heartburn**
- ☐ **Black/Bloody Stool**
- ☐ **Colitis**

NERVOUS SYSTEM CODE
- ☐ **Nervous**
- ☐ **Numbness**
- ☐ **Paralysis**
- ☐ **Dizziness**
- ☐ **Forgetfulness**
- ☐ **Confusion/Depression**
- ☐ **Fainting**
- ☐ **Convulsions**
- ☐ **Headaches**

GASTRO-INTESTINAL CODE
- ☐ **Poor/Excessive Appetite**
- ☐ **Excessive Thirst**
- ☐ **Frequent Nausea**
- ☐ **Vomiting**
- ☐ **Diarrhea**
- ☐ **Constipation**
- ☐ **Hemorrhoids**
- ☐ **Liver Problems**
- ☐ **Gall Bladder Problems**
- ☐ **Weight Trouble**
- ☐ **Abdominal Cramps**

GENITO-URINARY CODE
- ☐ **Bladder Trouble**
- ☐ **Painful/Excessive Urination**
- ☐ **Discolored Urine**

C-V-R CODE
- ☐ **Chest Pain**
- ☐ **Short Breath**
- ☐ **Blood Pressure Problems**
- ☐ **Irregular Heartbeat**
- ☐ **Heart Problems**
- ☐ **Lung Problems/Congestion**
- ☐ **Varicose Veins**
- ☐ **Ankle Swelling**
- ☐ **Stroke**

EENT CODE
- ☐ **Vision Problems**
- ☐ **Dental Problems**
- ☐ **Sore Throat**
- ☐ **Earaches**
- ☐ **Hearing Difficulty**
- ☐ **Stuffed Nose**

MALE/FEMALE CODES
- ☐ **Menstrual Irregularity**
- ☐ **Menstrual Cramps**
- ☐ **Vaginal Pain/Infection**
- ☐ **Breast Pain/Lumps**
- ☐ **Prostate/Sexual Dysfunction**
- ☐ **Other Problems**

_____

_____

FEMALES ONLY

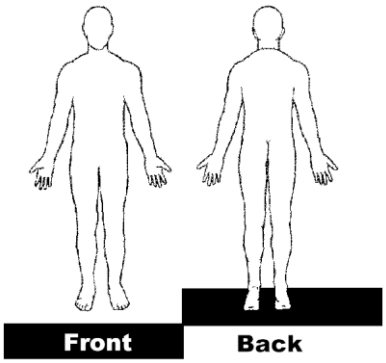
When was your last period?

_____

Are you Pregnant?

☐ **Yes** ☐ **No**

GENERAL CODE
- ☐ **Fatigue**
- ☐ **Allergies**
- ☐ **Loss of Sleep**
- ☐ **Fever**



Please outline on the diagram the area of your discomfort

The above health history and information is complete and accurate. If a new symptom or condition arises during my treatment, I will notify the doctor as soon as possible.

_____ _____

Patient Signature Date

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

ACCIDENT DETAILS

Date of accident: _____ Time of accident: _____ □ AM □ PM

In your own words, please describe the accident: _____

_____

_____

Below, please indicate the most accurate description of your role in this accident:

□ I was the driver □ I was a front passenger □ I was a rear passenger □ I was a pedestrian

Accident Site

Street Name: _____ City, State: _____

Driving Conditions: □ Dry □ Wet □ Icy □Other Visibility: □ Poor □ Fair □ Good □ Other

Your vehicle Information

Car make and model: _____ Please estimate cost of repair for your vehicle: _____ $

Were you wearing a seatbelt? □ Yes □ No Was the shoulder harness worn? □ Yes □ No

Was your vehicle moving? □ Yes □ No Speed of your vehicle: _____ mph

Did the airbag inflate? □ Yes □ No

Did your seat have a headrest? □ Yes □ No

If yes, please indicate the most accurate position of your headrest:

□ Top of headrest even with **bottom** of head □ Top of headrest even with **middle** of neck □ Top of headrest even with **top** of head

Other vehicle Information

Car make and model: _____ Estimated vehicle speed: _____ mph

Impact

Did your car impact another vehicle? □ Yes □ No Did your body strike anything inside the vehicle? □ Yes □ No

Location of impact on your vehicle: □ Front □ Rear □ Left □ Right □ Other: _____

Did you see the accident coming? □ Yes □ No

Did you brace for impact? □ Yes □ No

Were you breaking on impact? □ Yes □ No

Indicate your head/body position at the time of impact:

□ Head straight forward □ Head up/down □ Head turned right/left

□ Body straight forward □ Body rotated right/left □ Other _____

ILLUSTRATION OF THE ACCIDENT

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

PATIENT CONDITION RELATED TO ACCIDENT

Were you unconscious after the accident? □ Yes □ No If yes, for how long? _____
Could you move all parts of your body? □ Yes □ No
If no, which parts of your body couldn't move? _____
Why were you unable to move parts of your body? _____
Were you able to get out of the car and walk unaided? □ Yes □ No If no, why not? _____
Did you sustain any bleeding cuts? □ Yes □ No If yes, where was the cut? _____
Did you sustain any bruises? □ Yes □ No If yes, where was the bruise? _____
Please describe how you felt:
Immediately after the accident: _____
Later, the day of the accident: _____
The day following the accident: _____

TREATMENT RELATED TO ACCIDENT

Did you go to the hospital immediately after the accident? □ Yes □ No
If you responded no, please state when you went to the hospital, if applicable: _____
How did you get to the hospital?
□ Ambulance □ Police □ Someone drove me □ I drove my own car □ Other: _____
Hospital name: _____ Name of doctor seen: _____
Treatment received: _____
Medications given, if any: _____
Were any x-rays taken? □ Yes □ No If yes, which body region? _____
Did you seek any additional treatment? □ Yes □ No
If yes, what type of treatment? _____
Who did you see for this treatment? _____
Date of treatment? _____

SYMPTOMS RESULTING FROM ACCIDENT

Have you missed any days at work since the accident? □ Yes □ No If yes, how many? _____

Please check off the symptoms that you have experienced following the accident:

□ Arm/shoulder pain
□ Low back pain
□ Neck pain
□ Upper back pain
□ Chest pain
□ Leg pain
□Hand/finger numbness
□ Foot/toe numbness
□ Neck stiffness
□ Irritability
□ Nausea
□ Stomach upset
□ Chest pain
□ Headaches
□ Dizziness
□ Ear ringing
□ Memory loss
□ Jaw problems
□ Sleep difficulty
□ Blurred Vision
□ Shortness of Breath

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Dear Patient

It is our desire that you have as pleasant an experience in our office as possible. Our greatest concern is your health, but we also need to follow the billing protocol for personal injury care.

Please read the following and sing the bottom of this form.

1. YOUR insurance company is responsible for paying your bills, NOT the company of the person who hit you. If the accident was someone else's fault, your insurance company will seek compensation from their insurance company. After the first $2,000.00 of total Personal Injury Protection (PIP), benefits are paid out, and by law, we must bill your health carrier. If your health carrier does not provide chiropractic benefits or if you do not have health insurance, your PIP carrier will continue to pay your bills up to a total of $8,000.00.
2. It is your responsibility to obtain the following information from your insurance company
   I. Name
   II. Address
   III. Phone number
   IV. Fax number
   V. Claim number
   VI. Name and phone number of Bodily Injury Adjuster (NOT the adjuster of your car)
3. Your insurance company will send you a form called a "**PIP Application**." This form must be filled out by you as soon as it is received. Your insurance company will not pay your bills until this form is on file with them. Failure to send in your PIP application will result in bills incurred to become your responsibility.
4. If you have decided to utilize the help of an attorney, you and your attorney will need to sign a **Lien** form which will be held on file at this office. The Lien is used should you have any outstanding bills that are awaiting settlement to be paid.
5. At some point during your care, your insurance company may send you to another doctor for evaluation. This is called an Independent Medical Examination (IME). Please inform this office immediately if you are requested to seek an IME.
6. Keeping your scheduled appointments is imperative, not only for your recovery but also to ensure your claims will be paid. If an insurance company sees that you are missing appointments or changing your treatment plan without the recommendation of our doctors, they will assume that you are recovered and no longer need care.

I have read and understand the above information and agree to comply fully with the office policies of Khoury Chiropractic, Inc.

_____ _____

Patient Name Printed Date

_____

Patient Signature

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

PERSONAL INJURY INSURANCE INFORMATION

Your auto insurance information, or insurance information of vehicle owner

Name of insured, if other than yourself: _____

Name of insurance company: _____ Claim #: _____

Address of insurance company: _____

Medical adjuster: _____ Medical adjuster phone # _____ Ext. # _____

Have you been scheduled for an **Independent Medical Exam** (IME)? □ Yes □ No

Other driver's auto insurance information

Name of driver: _____

Name of insurance company: _____

Address of insurance company: _____

If applicable:

Name of attorney: _____ Phone: _____ Fax: _____

Address: _____

By law in Massachusetts, we must bill your personal health carrier after $2,000.00 of personal injury benefits have been exhausted. Please provide us with the following information about your personal health carrier:

Personal Health insurance company: _____

Health care card number: _____

I hereby authorize _____ insurance company to pay Khoury Chiropractic, Inc. directly for my healthcare costs. This payment will not exceed my indebtedness to Khoury Chiropractic, Inc. and I agree to pay any balance of professional services over and above this insurance payment.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

_____ _____

Patient Signature Date

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

IRREVOCABLE ASSIGNMENT OF BENEFITS FORM/LIEN

I hereby grant an irrevocable Equitable Lien and an *Official Legal Liens* as set forth in Ch111§70A through Ch111§70D Mass General Laws to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby assign and authorize any and all medical benefits from any insurance plan or any other protection maintained by the patient and/or for the patient's behalf to which I am entitled, including but not limited to, Personal Injury Protection Benefits (PIP), optional medical payments benefits, disability insurance, bodily injury insurance, uninsured/underinsured insurance, worker's compensation, or any other private insurance or health plan be paid directly to:

KHOURY CHIROPRACTIC, INC.
640 Washington Street
Dedham, MA 02026
Tax ID: 04-3520390

For treatment resulting from an accident on _____ in _____ and rendered by Khoury Chiropractic Inc. and all medical staff associated with them.

I certify that the information given by me to Khoury Chiropractic Inc. in applying for payment under insurance plans or other protection is correct and complete.

I authorize all procedures related to my diagnoses, whether covered or not by my insurance plan, and I understand that I am financially responsible for all charges in excess of the plan's payment schedule and any charges incurred due to non-covered services.

I hereby authorize Khoury Chiropractic Inc. to release all information necessary including confidential medical records to any insurance company, adjuster, or attorney involved in collection of this matter in order to secure payment.

I hereby authorize Khoury Chiropractic Inc. to endorse/sign my name on and deposit any and all checks payable for their services. Should an insurance check be sent to me, I agree to forward it immediately to Khoury Chiropractic Inc.

I also understand that Khoury Chiropractic Inc. may file any appropriate complaint on my behalf.

A photocopy of this assignment is considered as effective and valid as the original for any successive services.

I understand this is an Irrevocable and Direct assignment of benefits.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

640 Washington Street
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(781) 329-3344

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KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

NOTICE OF IRREVOCABLE LIEN AND ASSIGMENT OF BENEFITS AUTHORIZATION

Patient name: _____ Patient address: _____

Date of Injury: _____ Insurance carrier: _____ Claim #: _____

Law office: _____ Attorney Name: _____

In consideration of the agreement of the provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my provider all my right, title, and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: automobile PIP coverage; Medical Payment Coverage and health care coverage to which I may be entitled to pay my provider for services rendered to treat me on and after the above date.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him or her for professional services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as maybe necessary adequately to protect said doctor. I hereby further grant an irrevocable Equitable Lien and an Official Legal Liens as set forth in Ch111§70A through Ch111§70D Mass General Laws to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said provider for all benefits and sums due me that may be due him or her upon receipt by you of my providers itemized statement for treatment services rendered to me. It is further agreed that payment by any insurance company involved as herein directed to my provider of any itemized statement shall be considered the same as if paid by the insurer directly to me.

I fully understand that I am directly and fully responsible to said doctors for all professional bills submitted by him or her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. I am aware that I remain personally responsible to my provider for the full amount of my unpaid treatment bills and I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____

Patient Signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment verdict as may be necessary adequately to protect the said doctor named above.

_____ _____

Attorney Signature Date

Attorney: Please date, sign, and return one copy to doctor's office at once. Keep one copy for your records.

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Authorization to Use or Disclose Protected Health Information

I hereby authorize Khoury Chiropractic, Inc. to use or disclose the following protected health insurance information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Information to be disclosed to: Andrews Billing Solutions Inc

Disclose the following information for treatment dates: _____ to _____.

- ☐ Complete Records
- ☐ Consult
- ☐ Physical Therapy
- ☐ Abstract
- ☐ Outpatient Reports
- ☐ Emergency Reports
- ☐ Face Sheet
- ☐ X-ray
- ☐ Bills
- ☐ Discharge Summary
- ☐ Laboratory
- ☐ History & Physical
- ☐ Pathology
- ☐ Super Statement
- ☐ Last Date of Service
- ☐ Other (Specified) All Insurer reports and records generated because of an examination(s) and/or review(s) of client/patient/insured and/or medical documentation relating to the _____ date of loss.

The above information is being disclosed for purposes of treatment and payment of services.

I understand that I may revoke this authorization at any time by requesting such from the above referenced physician/facility/provider/hospital/practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization expires on (or upon) _____
Insert Applicable Date and/or event

_____ _____
Patient Name Printed Date

_____
Patient Signature

_____ _____
Name of Patient's Representative Relationship to patient or authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL APPLICABLE ITEMS ARE COMPLETED.

A photocopy of this form shall have the same authority as the original

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

HEALTH INSURANCE AFFIDAVIT

In order to properly determine what benefits are payable, it is necessary for you to provide us with the information requested below. Thank you very much.

Do you have Health Insurance? ☐ Yes ☐ No

If yes, please answer the following, or provide a copy of your health insurance card.

Plan Name: _____

Member ID Number: _____ Group Number: _____

Subscriber Name: _____

☐ Yes ☐No

If no, are you eligible for coverage under someone else's health plan?

Member Name: _____ Relationship: _____

Address of the member: _____

Member phone number: _____

_____ _____
Applicant Signature Date

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KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Memorandum of Understanding for Non-Covered Services

Section I: Introduction

This memorandum is being provided to you specifically for items and/or services that our office believes will **not** be covered by your health care carrier. Upon verification of benefits either online or via telephone with your health care carrier, it is our understanding that the items and/or services checked off in Section II below are not going to be covered when performed in this office by our providers.

Section II: Items / Services Not Covered

- ❑ Examinations
- ❑ Therapies
- ❑ Re-Examinations
- ❑ Modalities

Section III: Costs

The total costs for these services are estimated to be $_____. This is based on our posted fee schedule.

Section IV: Time of Service Discounts

Our office can offer a time-of-service discount. This discount can only be offered if payment is made at the time the services are being performed. You can take advantage of this discount by making payment today. **If you choose not to take advantage of this savings, then the regular posted rates will be billed to your health care carrier. You will be responsible for the full fee if your insurance does not cover these items and/or services.** Your total obligation if payment is made today is $_____.

Section V: Agreement and Understanding

Please check off your decision below and sign where indicated. Your signature indicates your complete understanding of your financial obligation. This signature also acknowledges that our office has communicated to you our understanding of your health coverage and specifically that our office believes that the items and/or services checked off in Section II will **not** be covered.

Please check off the option that suits you best:

- ❑ OPTION 1: I will pay the amount indicated in Section IV and take advantage of the time-of-service discount. I understand that if my health carrier does cover some or all of the services in Section II, our office will credit my account and issue a refund to me.

- ❑ OPTION 2: I choose to have the services submitted to my health carrier at the posted fee schedule in the estimated amount listed in Section III. **I understand that I am declining to take advantage of the time-of-service discount that is being offered to me today and that I will be fully responsible in paying the amount listed in Section III.**

_____ _____
Patient Name Printed Patient Date of Birth

_____ _____
Patient Signature Date

_____
Witness Name Printed

_____ _____
Witness Signature Date

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KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Memorandum of Understanding – Out of Network with your Health Insurance Carrier

Patient Name: _____ Patient Date of Birth: _____

Date of loss: _____

Out of network health insurance carrier: _____

Health insurance ID number: _____

This notice is to advise you that our office is not in network with your health insurance carrier. We have verified benefits with your health insurance carrier and there are no out-of-network benefits available to you for services rendered here.

As there are no out-of-network benefits available to you at this office, we have prepared this memorandum to advise you in writing that you are responsible for the accruing balance due if you choose to remain at our facility and receive care,

By signing this notice, you understand that all your care will not be paid by your health insurance carrier. You further understand that the balance will be expected at the time your care is settled and that payment shall be made from your attorney directly to our office from the settlement proceeds.

This notice is acknowledgement that you understand this memorandum. Your signature shall signify your acceptance of this memorandum and that you choose to continue care in this office despite the fact that you have no coverage under your health insurance carrier.

_____
Patient Name Printed

_____ _____
Patient Signature Date

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.