

SIGNATURE OF PATIENT

The following policies have been updated for 2025. Please review and initial beside each policy, acknowledging you understand and agree. MISSED APPOINTMENT POLICY: A \$50.00 fee will be charged to all accounts that miss an appointment without 24-hour notice. All cancellations and reschedules must be made by calling or texting. NO emails. This is not a fee that can be submitted to your insurance. **INSURANCE:** Current insurance MUST be presented at the time of service. We will not go back to correct claims processing because of missing or invalid insurance. This applies to primary and secondary insurance policies. In the event your insurance does not process a claim, or they reverse previously processed claims for any reason, we will not be able to go back more than 90 days to re-submit claims. This is a Timely Filing limitation set by insurance companies. You will be financially responsible for the self-pay office visit rate for all appointments older than 90 days. CARD-ON-FILE POLICY: All accounts are required to have a credit card on file to cover fees, copays, co-insurance and deductibles. See separate form. **COLLECTIONS:** Unpaid balances of five to nine months or more will incur an 8% late fee per month of the outstanding balance. After nine months, the account will be turned over to a collection agency. HIPAA: I acknowledge that I have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. I consent to the use of my health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law. PRINTED NAME OF PATIENT MINOR(S)

**TODAY'S DATE** 

## **2025 EMERGENCY CONTACT PERSON**

EMERGENCY CONTACT #2	RELATIONSHIP	PHONE NUMBER
ORIZED PEOPLE WHO HAVE	ACCESS TO MY INFORMATION	
· · · · · · · · · · · · · · · · · · ·	ctic of St. Michael to share my accour ON, PAYMENT DETAILS, AND APPOIN n)	_
NAME		RELATIONSHIP TO PATEINT
		RELATIONSHIP TO PATEINT
NAME		
		RELATIONSHIP TO PATEINT
NAME  Please do NOT allow ar	nyone to access my information	

## **2025 Policy Changes and Authorizations**

## **AUTHORIZED CARD-ON-FILE**

Name

Name

**SIGNATURE** 

I am providing Great Lakes Chiropractic of St. Michael with a credit card to be stored securely and used for all fees, co-pays, and/or co-insurance or deductibles after insurance has processed my claims. The card on file can be changed or removed at any time by contacting Great Lakes Chiropractic of St. Michael.

(Initial)	_ The card-on-file will only be use	ed in these situations:		
(middy	a) when authorized by you to pay your balance			
	b) automatically when you have	ve a past due balance of over 60 days		
	c) automatically for a missed	appointment fee		
	d) automatically when you ca	ncel/reschedule an appointment with less than 24-hour		
	notice			
•	respond promptly when Great La work or has expired.	kes Chiropractic of St. Michael notifies me that my card-on-fi	le	
This card-	on-file can be used for the follow	ring people or family members:		
Name		Relationship		
Name		Relationship		
Name		Relationship		

Relationship

Relationship

TODAY'S DATE

Security note from Rectangle Health, the credit card processing software vendor:

"All cards are electronically stored and encrypted in the payment portal software, such that no direct staff at Great Lakes Chiropractic or support staff at Rectangle Health can view your information at any point, beyond the last 4 digits. Once imbedded into the software the information is encrypted and stored.