PATIENT AGREEMENT
MCPHERSON CHIROPRACTIC CENTER

This is an Agreement entered into on _____ , 20___, between

_____ of McPherson Chiropractic Center (Clinic, Us or We),

and_____ (Patient or You).

Background

In exchange for certain fees, the CLINIC, agrees to provide You with the Services described in this Agreement on the terms and conditions contained in this Agreement.

Definitions

1. Patient. In this Agreement, "Patient" means the persons for whom the Physician shall provide care, and who have signed this agreement or are listed on the document attached as Appendix 1, which is a part of this agreement.

2. Services. In this Agreement, "Services", means the collection of services, offered to you by US in this Agreement. These Services are listed in Appendix 1, which is attached and a part of this Agreement.

Agreement

3. Term. This Agreement will last for one year, starting on _____.

4. **Renewal.** The Agreement will automatically renew each year on the anniversary date of the agreement, unless either party cancels the Agreement by giving 30 days written cancellation notice.

5. Termination. Regardless of anything written above, You always have the right to cancel this agreement. Either party can end this agreement at any time by giving the other party 30 days written notice.

6. Payments and Refunds – Amount and Methods. In exchange for the Services (see Appendix 1), You agree to pay Us, a monthly fee in the amount that appears on Appendix 3, which is attached and is Part of this Agreement.

a) This monthly fee is payable when you sign the Agreement, and is due no later than the first business day of each month thereafter.

b) The Parties agree that the required method of monthly payment shall be by cash, check, or automatic payment, through a credit card or debit card.

c) If this Agreement is cancelled by either party before the Agreement ends, We will

review and settle your account as follows:

(i) We will refund to You the unused portion of your fees on a per diem basis; or

(ii) If the Value of the Services you received over the term of the Agreement exceeds the amount You paid in membership fees, You shall reimburse the CLINIC in an amount equal to the difference between the value of the services received and the amount You paid in membership fees over the term of the Agreement. The Parties agree that the value of the services is equal to the CLINIC's usual and customary fee-for-service charges. A copy of these fees is available on request.

7. Non-Participation in Insurance. Your initials on this clause of the Agreement acknowledges the Patient's understanding that neither the CLINIC, nor its Physician, will be submitting to any health insurance or HMO plans or panels. Neither make any representations that the fees paid under this Agreement are covered by the Patient's health insurance or other third party payment plans. It is the Patient's responsibility to determine whether reimbursement is available from a *private, non-governmental* insurance plan or HSA and to submit any required billing. **_____ (Initial)**

8. Medicare. This agreement acknowledges the Patient's understanding that Medicare cannot be billed for any maintenance services performed for the Patient by the Physician. The Patient agrees not to bill Medicare or attempt to obtain Medicare reimbursement for any such services. If the Patient is eligible for Medicare, or becomes eligible during the term of this Agreement, then she/he has the option to have his/her treatment billed to Medicare. This intern will discontinue this agreement. The patient can elect to sign a new agreement. The Patient shall sign and renew the Medicare ABN and Waiver Agreement every year, as required by law.

_____ (Initial)

9. This Is Not Health Insurance. Your initials on this clause of the Agreement acknowledge Your understanding that this Agreement is not an insurance plan or a substitute for health insurance. The Patient understands that this Agreement does not replace any existing or future health insurance or health plan coverage that Patient may carry. The Patient acknowledges that the CLINIC has advised the patient to obtain or keep in full force, health insurance that will cover the Patient for healthcare not personally delivered by the CLINIC, and for hospitalizations and catastrophic events.

_____ (Initial)

10. Change of Law. If there is a change of any relevant law, regulation or rule, federal, state or local, which affects the terms of this Agreement, the parties agree to amend this Agreement to comply with the law.

11. Severability. If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part will be amended to the extent necessary to be enforceable and the remainder of the contract will stay in force as originally written.

12. Reimbursement for services rendered. If this Agreement is held to be invalid for any reason, and the CLINIC is required to refund fees paid by You, You agree to pay the CLINIC an amount equal to the fair market value of the medical services You received during the time period for which the refunded fees were paid.

13. Amendment. No amendment of this Agreement shall be binding on a party unless it is in writing and signed by all the parties. Except for amendments made in compliance with Section 11, above.

14. Assignment. This Agreement, and any rights You may have under it, may not be assigned or transferred by You.

15. Legal Significance. You acknowledge that this Agreement is a legal document and gives the parties certain rights and responsibilities. You also acknowledge that You have had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.

16. Miscellaneous. This Agreement shall be construed without regard to any rules requiring that it be construed against the party who drafted the Agreement. The captions in this Agreement are only for the sake of convenience and have no legal meaning.

17. Entire Agreement. This Agreement contains the entire agreement between the parties and replaces any earlier understandings and agreements whether they are written or oral.

18. **No Waiver.** In order to allow for the flexibility of certain terms of the Agreement, each party agrees that they may choose to delay or not to enforce or the other party's requirement or duty under this agreement (for example notice periods, payment terms, etc.). Doing so will not constitute a waiver of that duty or responsibility. The party will have the right to enforce such terms again at any time.

19. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Kansas. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the CLINIC in McPherson, Kansas.

20. Service. All written notices are deemed served if sent to the address of the party written above or appearing in Appendix 2 by first class U.S. mail.

The parties may have signed duplicate counterparts of this Agreement on the date first written above.

MCPHERSON CHIROPRACTIC CENTER	Name of Doctor (printed)
Signature of Patient	Name of Patient (printed)
Date	

APPENDIX 1
SERVICES

1. **Chiropractic Services.** Chiropractic Services under this agreement are those services that the Chiropractic Physician is permitted to perform under the laws of the State of Kansas, are consistent with Physician's training and experience, are usual and customary for a chiropractic physician to provide, and include the following:[1]

- Initial Examination
- Re Examination(s)
- School Physicals (PPEs)
- Chiropractic Adjustments
- Electrical Muscle Stimulation
- Therapeutic Ultrasound
- Myofascial Release (MFR)
- Cold Laser
- Kinesiology Taping
- Nutritional Counseling*
- Spinal Decompression*
- Acupuncture*

a. ***Physician Absence.*** From time to time, due to vacations, illness , or personal emergency, the Physician may be temporarily unavailable to provide the services referred to above in this paragraph one. In order to assist Patients in scheduling non-urgent visits, CLINIC will notify Patients of any planned Physician absences as soon as the dates are confirmed. In the event of the Physician's unplanned absences, Patient's will be given the name and telephone number of an appropriate provider for the Patient to contact. Any treatment rendered by the substitute provider is not covered under this contract, but may be submitted to Patient's health plan.

b. ***No Wait or Minimal Wait Appointments.*** Reasonable effort shall be made to assure that Patient is seen by the Physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If Physician foresees a minimal wait time, every effort shall be made to contact Patient to advise them of a prolonged wait time.

c. ***Same Day/Next Day Appointments*.** When Patient calls the Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. If the patient calls or e-mails the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Physician on the following normal

[1] As deemed appropriate and medically necessary by the Physician.
*Other potential services that may be offered

office day. In any event, however, CLINIC shall make every reasonable effort to schedule an appointment for the Patient on the same day that the request is made.

d. ***Specialists Coordination.*** CLINIC and Physician shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. **Patient understands that fees paid under this Agreement do not include and do not cover specialist's fees or fees due to any medical professional other than the CLINIC Physician.**

APPENDIX 2
PATIENT ENROLLMENT – AGREEMENT FORM
MCPHERSON CHIROPRACTIC CENTER

Annual fees as set out below shall apply to the following Patient(s), who by signing below agree to the terms and conditions of the MCPHERSON CHIROPRACTIC CENTER Agreement Form.

Printed Name | Date of Birth (MM/DD/YYYY) | Age

Street Address | City, State, Zip

Home Phone | Work Phone | Cell Phone | Preferred email

Spouse Name | Date of Birth (MM/DD/YYYY) | Age

Home Phone | Work Phone | Cell Phone | Preferred email

Child/Children to Whom this Agreement Applies:

Print Name | Date of Birth (MM/DD/YYYY) | Age

Print Name | Date of Birth (MM/DD/YYYY) | Age

Print Name | Date of Birth (MM/DD/YYYY) | Age

Print Name | Date of Birth (MM/DD/YYYY) | Age

Preferred Payment Method*

□ Yearly (Credit/Debit Card)

□ Monthly (Credit/Debit Card/Check)

□ Employer_____

*All patients must have a credit or debit card on file to cover the cost of membership and any incidentals not covered under the Agreement.

I certify that I have read, understand, and agree to the terms set forth in MCPHERSON CHIROPRACTIC CENTER Agreement Form. I further certify that I have received a copy of this form.

Signature: _____

APPENDIX 3
FEE ITEMIZATION

19+ years of age	$50 per month
0-18 years of age	$10 per visit*

$50/Month – Member receives 2 visits at no extra charge and $10 for every visit thereafter.

*With the enrollment of at least one adult member.

Patient 1	$_____
Patient 2	_____
Additional Patients	_____
TOTAL RATE	$_____