FOSTERING WELLNESS
CHIROPRACTIC

135 W. Dimond BLVD Ste #104
Anchorage, Alaska 99515
P: (907) 344-3444 F: (907) 921-7670
Fosteringwellness.com

Last Name: _____ First Name: _____

Mailing Address: _____

_____

Physical Address: _____

_____

Cell Phone #: _____ Home Phone #:_____

Work Phone #: _____ Email: _____

DOB: _____ Birth Gender: (Circle One) Female Male

Emergency Contact: _____ Contact Phone #: _____

Payment is due at the time of services; payment includes any co-payment or deductible requirements set by your insurance company or total amount due for non-insured patients. Accounts with balances greater than 90 days may be referred to a collection agency and can incur additional fees, which may be added to the delinquent account. FWC will submit your billing claims to your insurance company; it is your responsibility to furnish all insurance information correctly prior to treatment. We cannot quote or guarantee your benefits and feel that your role in managed care participation is to know your benefits and alert us of any non-covered services.
Insurance balances greater than 90 days and all non-covered services will be billed to the patient.
Please remember that your insurance policy is an agreement between a patient and their insurance company.
Any co-payments required by an insurance company ***must*** be paid at the time of service.

Release of Information

I, _____, authorize FWC to release any information to consulting medical providers, insurance companies or any third-party payor so that they may obtain payment for medical services rendered. I authorize the insurance companies or any third party to pay any benefits directly to the providers of FWC, realizing that I am responsible for all non-covered services.

_____ Date: _____
Signature of Patient or person authorized to consent for patient.

Consent to Treat

I do hereby give my consent to FWC to provide medical care and treatment that is considered necessary and proper in diagnosing and treating my condition. Consent to treat may consist of but not limited to; chiropractic adjustments, medical advice, X-rays, and therapies such as: traction, ultrasound, electrical stimulation, massage, and other treatments/ tests as needed.

_____
Printed name of patient or person authorized to consent for patient.

_____ Date: _____
Signature of Patient or person authorized to consent for patient.

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Patient Name: _____ DOB: _____

Fostering Wellness Chiropractic (FWC) Massage/ Manual Therapy Policy

Listed below are the policies for scheduling, canceling, and re-scheduling massage/ manual therapy appointments.

1. A 24-hour notice is ***required*** for cancelling or re-scheduling your massage/ manual therapy appointments.
   If a 24-hour notice is not given, **you will incur a $75 late cancellation charge**.
   Leaving a message on the recorder the evening before will suffice as a 24-hour notice.

2. Our massage/ manual therapy appointments scheduled every hour on the hour.
   Please arrive a few minutes early for your appointment.
   If you run late for your appointment, it will affect your appointment time and you will not receive a full massage/ manual therapy appointment time.
   If you run more then 30 minutes late, your appointment will be canceled
   and **you will incur a $75 late cancellation charge**.

3. Please be responsible for knowing when your appointments are scheduled.
   FWC will send out text reminders the evening before your appointments, however,
   technology does not always work properly.

Thank you for understanding and complying with our massage/ manual therapy policies.
These policies are put in place because our therapists time is very valuable and cannot always be filled on short notice.
If you have any questions or concerns, please see our business manager so that we may address your questions and concerns.

Patient / Guardian Signature: _____ Date: _____