



# Maryville, Knoxville, Knoxville North & Madisonville Chiropractic Financial Policy

## Insurance

Group insurance is an agreement between you and your insurance company, not between your insurance company and this center. As a courtesy to our patients, our office will complete any necessary reports and forms at no charge and file them with your company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible. We request that each patient who wishes to file insurance through this office pay the insurance policy deductible and the patient's percentage as stated in your policy. When all insurance checks have been received, we will refund any overpayment to you.

## Patients Without Insurance

1. We request that 100% of the first visit be paid at the time of the first visit.
2. We are happy to accept your check, MasterCard, Visa, Discover, or American Express

## On the Job Injury

Worker's Compensation pays in full for chiropractic care. Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this period, or if you have suspended or terminated your care without your doctor's approval, payment for services is immediately due.

## Personal Injury or Automobile Accidents

Please present your auto insurance forms as soon as possible. If an attorney is handling your case, please notify the insurance department right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

## Medicare

We do accept assignments from Medicare. After the patient's \$100 deductible has been met for the year, Medicare will pay 80% of the visits they approve. The other 20% is due by the patient. Medicare does not cover examinations or x-rays, but they do require x-rays to be taken before they will approve any visits.

## Medicare Supplements

This office processes Medicare Supplements.

Some TennCare is accepted.

I understand and agree that health and accident insurance policies are an agreement between my insurance company and myself, not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete my usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I, the undersigned, have and agree with the above policy.

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Patient

Date

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Witness

Date

*INSTITUTE OF ALTERNATIVE HEALTHCARE*

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Chiropractic Physicians

Dr. Woodrow W. Gwinn, Jr.  
Maryville Chiropractic  
Clinic  
1812 E. Lamar Alexander Pkwy.  
Maryville, TN 37804  
(865) 977-0916 Fax (865) 984-3519

Dr. O. Brandon Forrester  
Madisonville Chiropractic  
Clinic  
3912 Hwy. 411  
Madisonville, TN 37354  
(423) 442-4153 Fax (423) 442-9632

Dr. Terrance J. Loher  
Knoxville Chiropractic  
Clinic  
2725 Asbury Rd. Suite 105  
Knoxville, TN 37914  
(865) 541-6797 Fax (865) 541-6794

Dr. Rafael M. Rodriguez  
Knoxville Chiropractic  
Clinic North  
1713 Dry Gap Pike  
Knoxville, TN 37918  
(865) 687-9797 Fax (865) 687-9881

**HEALTH REVIEW**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Please mark (X) all present symptoms.**

- ( ) Eczema
- ( ) Itchy Skin
- ( ) Psoriasis
- ( ) Bruise easily
- ( ) Sinusitis
- ( ) Allergies
- ( ) Indigestion
- ( ) Abdominal Pain
- ( ) Diarrhea
- ( ) Constipation
- ( ) PMS
- ( ) Nervousness
- ( ) Anxiety
- ( ) Fatigue
- ( ) Depression
- ( ) Sleeplessness
- ( ) General Swelling
- ( ) Arthritis
- ( ) Headaches
- ( ) Muscle Spasms
- ( ) Muscle Aches
- ( ) Sciatica
- ( ) Poor Circulation
- ( ) TMJ
- ( ) Thyroid Problems
- ( ) Flat Feet

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I, \_\_\_\_\_, do certify that there was no accident, which caused my injuries,  
and I do not have any other medical insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**Web address: [www.instituteofalternativehealthcare.com](http://www.instituteofalternativehealthcare.com)**

**E-mail address: [chiroid@aol.com](mailto:chiroid@aol.com)**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insured Primary Ins. SS#/ID#: \_\_\_\_\_ Group/Claim #: \_\_\_\_\_

Secondary Ins. SS#/ID#: \_\_\_\_\_ Group/Claim#: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

Dr. Woodrow W. Gwinn, Jr.  
1812 E. Lamar Alexander Pkwy.  
Maryville, TN 37804  
Telephone (865) 977-0916

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make the check to me and mail it as follows:

Dr. Woodrow W. Gwinn, Jr.  
1812 E. Lamar Alexander Pkwy.  
Maryville, TN 37804  
Telephone (865) 977-0916

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature of policyholder: \_\_\_\_\_

Signature of Claimant, if other than policyholder: \_\_\_\_\_

Witness: \_\_\_\_\_

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**INFORMED CONSENT FOR CHIROPRACTIC CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including (but not limited to) various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure that the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and, by signing below, I agree to the above consent. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian in case of minor: \_\_\_\_\_

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health-related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian in case of minor: \_\_\_\_\_

I give you permission to use my name in your patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian in case of minor: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_