



LANCE HAGER, DC  
CHIROPRACTIC PHYSICIAN  
WY LICENSE: 561

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Monday, October 30, 2017

## OFFICE POLICY

**Please give us 24 hours notice if you are unable to keep your appointment.**

- If you are more than 15 minutes late for your appointment we will have to reschedule your appointment or we will be happy to look at our appointment book to see if we have had any cancellations for later in the day.
- Please notify us of any change in insurance, address, home or work telephone numbers.
- We accept payment by cash, check or credit card.
- If you do not have insurance, payment is due in full at the time of service.
- If your insurance makes you responsible for a set co-pay per office visit, this amount is due at the time of your visit.
- We will bill your insurance company whether or not we are providers for them. However, once we determine that our treatment is applied towards your co-pay or deductible, we will bill you for this amount.
- Payment is due, in full, upon receipt of the first statement you receive unless you contact us to set up payment arrangements. Any account past 120 days will be subject to collection proceedings.
- I understand that I am responsible for all attorney fees, court costs or delinquency fees that may be incurred during the collection of my debt. I understand that the delinquency fee will be equal to 50% of the principle amount owed.

**TO AVOID ANY MISUNDERSTANDING, PLEASE DO NOT HESITATE TO DISCUSS ANY ASPECT OF OUR OFFICE AND PAYMENT POLICIES WITH US.**

**THE HIPAA PRIVACY ACT NOW REQUIRES US TO OBTAIN A COPY OF YOUR PICTURED ID AND INSURANCE CARD FOR OUR FILES. THESE COPIES WILL BE PLACED IN YOUR PERSONAL, CONFIDENTIAL FILE.**

**To be in compliance with the HIPAA Privacy Act, we are required to have your signature giving us permission for the following:**

- ✓ I authorize Lance R. Hager, DC and office staff to call me by my first name, middle name or last name.
- ✓ I authorize Lance R. Hager, DC and office staff to disclose information from my medical record to any person or corporation which is or maybe liable under a contract to the doctor or patient or to a family member or employer for all or part of the physician's charge including but not limited to medical service companies, insurance companies, workers' compensation carriers, welfare funds, the patient's employer or to any healthcare or extended care facility that I may be transferred to in the event it is deemed appropriate to make such transfer or referral.
- ✓ I authorize Lance R. Hager, DC and office staff to speak by phone or in person with my insurance company, workers' compensation carriers, welfare funds, the patient's employer or to any health care or extended care facility regarding your care and billing for services rendered at this facility.

**I have read and understand and agree with the above policies.**

**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_