~PRIVACY PRACTICES ~

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant To HIPAA and Consent for Use of Health Information and Permission To Contact and Release of Information

_________________________ Date: ______________________

Print the Patient Name

The undersigned does hereby acknowledge that he/she has received a copy of this Office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA Compliance Manual State Law and Federal Law.

In order to improve communications between the office and our patients, we will be calling to confirm your appointment. Also, there may be times when we need to speak to you personally regarding your appointment, treatment or other health information. Please provide how and where you would like to be contacted.

Please contact me at: HOME___________ CELL__________ WORK__________

_______Please leave a message on my voicemail, but only to indicate you have called.

_______Please leave detailed information on my voicemail.

_______You may at any time release my confidential health information to:

____

Name Relationship to the Patient Phone Type Phone Number

____

Signature of Patient/Guardian/Parent

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OFFICE STAFF ONLY...............WITNESS/DATE

Chiropractic Health Center, 620 Collins Drive, Festus, Missouri 63028
Dr. Elizabeth Schoenekase, Dr. Donald Rueschhoff, Dr. Matt Pilgrim

CHIROPRACTIC HEALTH CENTER
OFFICE FINANCIAL & CANCELLATION POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible can be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment each visit.

3. We accept assignment as a courtesy to you, HOWEVER, you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. **We** are not a mediator between you and your insurance company and **will not** enter into any **dispute** with the same, as **your contract** is **between you and your insurance company.**

4. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

6. This office will submit a claim **ONE TIME**. **We will not** enter into any **dispute with your insurance company.** If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services.

CHIROPRACTIC HEALTH CENTER
OFFICE FINANCIAL & CANCELLATION POLICY

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.

NON PAYMENT

1. You are personally responsible for the total amounts due this Office for all services rendered. If at anytime the amounts due this Office become ninety (90) past due, with the balance being Your Responsible Amount, this Office will demand payment in full. There will also be interest charged to the account at a rate of 7% per month after ninety (90) days until the account is paid in full.

2. If a delinquent account is turned over to Collections, or continues to Legal Action, then you will be responsible for the principal, interest, attorney fees, collection fees and court cost.

I have read and understand the Financial Office Policy and agree to abide by these terms.

________________________________ ____________________

Patient's Signature **Date**

CANCELLATION NOTICE

Our patients are our priority! We want to make sure you get the necessary treatment you deserve and need. When you schedule an appointment, you are making it a priority to take care of yourself, and, making a commitment to your health. Our Physician(s) take the necessary time that is needed to take care of YOU. It is very important for you to keep your scheduled appointment(s). If you cannot make your scheduled appointment, please call **within 24 hours**, to reschedule/cancel to avoid an extra charge to your account of **$15.00.** It will be up to our discretion to charge/not charge based upon your particular situation, **HOWEVER,** we will **NOT** tolerate multiple missed appointments, multiple reschedules, or just plain "No Shows."

I have read and understand the Cancellation Notice and agree to abide by these terms.

Patient Signature____ **Date**__________