INTEGRATIVE
CHIROPRACTIC
AND EXTREMITIES

CONSENT FORM

Patient Acknowledgment Receipt for Consent to Use and Disclosure of Protected Health Information

Use and disclosure of your Protected Health Information

Your PHI (Protected Health Information) will be used by Integrative Chiropractic and Extremities to authorize and disclose to others for purposes of treatment, obtaining payment, or health care operations of this office.

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment; however, private areas are available upon request. You may refuse to sign this acknowledgment and authorization and revoke this consent to use PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing information by means:

Patient Acknowledgment Contact

- ❑ Cell phone
- ❑ Home phone
- ❑ Text message
- ❑ Email
- ❑ All of the above

I acknowledge receipt of a copy of the office "Notice of Patient Privacy Policy"

_____

Patient or legal authorized individual signature Date

_____

Printed name of Patient

_____

Sign Guardian of Patient Relationship Date

Office use only - As compliance office, attempt to obtain patient's signature of this notice was not obtained because:

_____

Signature of Privacy Officer

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FINANCIAL POLICY

***Our office is primarily a cash-based clinic. All payments are accepted on a cash basis (cash, check, and credit card payments). Payment is expected at the time of services rendered.**

This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed after your Report of Findings visit.

Patients With Insurance: Major Medical or Group Health Insurance (PPO, HMO, etc.): Integrative Chiropractic and Extremities does not participate in any major medical or group health insurance plans. Our policy is to not accept assignment of benefits nor file insurance claims for these types of insurance plans. We will provide you with a **superbill** (receipt) so that you can file a claim with your insurance company to get reimbursed for your eligible benefits*.

**We do this as a benefit primarily for the patient. Our belief is that insurance companies may too often dictate care only considering the financial value of the patient while neglecting what is ultimately best for their health. This policy importantly allows our doctors to spend more time with the patient and less time on paperwork which ultimately translates to better outcomes and a more engaged experience at our clinic.*

Medicare: We accept assignment from Medicare. The check is usually sent directly to our office in payment for the services that Medicare will cover, which for Chiropractors is ONLY manual manipulation of the Spine. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare and any secondary insurance at no charge.

Personal Injury Cases: We may accept assignment and file insurance claims for patients involved in auto accidents or other personal injury cases. The patient is responsible for any deductible, coinsurance, and any services not covered or reduced by the insurance company.

- If the patient has obtained the services of an attorney, we may accept a Lien or Letter of Protection from the attorney to defer payments from the patient. The patient remains personally responsible for all amounts due to Integrative Chiropractic and Extremities

We do request a **minimum of 24-hour advance notice** for any cancellation or rescheduling of your appointment. This is a consideration to our Health Practitioners as well as to our Patients whom would be able to utilize this time for their own health needs. Short notice or no notice will incur an office visit charge if it becomes a regular occurrence. We appreciate your cooperation in this matter.

Refund Policy: Any unused prepaid visit fees will be refunded within **15 days** upon request or may remain as a credit towards future visits. You may decide at any time not to continue your prepayment billing arrangement, subject to payment of office visits that have already occurred, without financial penalty.

If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor. Thank you!

I have read and understand Integrative Chiropractic and Extremities's Financial Policy and agree to abide by these terms.

_____ _____

Patient Signature Date