

Name of Patient: \_\_\_\_\_

**EXPECTATIONS FOR CHIROPRACTIC CARE**

You have just started Chiropractic Care, which is a TEAM EFFORT between you and your Chiropractor. As such, this requires some effort on your part in:

- 1) Following directions of recommendations made
- 2) Performing your home program if instructed to do so.
- 3) Regular attendance of your scheduled visits.
- 4) Contact your Chiropractor if there is any difficulty/problem.

People who follow the above obviously do far better than those who do not. Following directions and making your appointments demonstrates responsibility on your part to improve your own physical health. Therefore, for people who miss appointments, this either delays or interferes with their own progress. If unforeseen circumstances force you to CANCEL a visit, out of respect for the other patients who are on a waiting list, we ask you give us at least 24 hours notice if you need to make a cancellation. Someone else is waiting for that appointment time should you not be able to attend. We have 24 hour voice messaging so you can call us AT ANY TIME. If you miss a visit or "No-Show" you will be charged a fee. If a patient has 2 No-Show visits (this means they did not contact us), this demonstrates a lack of responsibility and therapy will be put on hold.

We look forward to giving you the best chance at reaching your goals and achieving your potential.

Creative Chiropractic Solutions Staff

PLEASE READ THIS DOCUMENT COMPLETELY. BY PLACING YOUR INITIALS ON THE APPROPRIATE LINE INDICATES YOU HAVE READ THAT SECTION AND YOUR SIGNATURE AT THE BOTTOM OF THE FORM INDICATES THAT YOU AGREE WITH THIS DOCUMENT IN ITS ENTIRETY.

**CONSENT FOR CARE AND TREATMENT**

I do hereby agree and give my consent for Creative Chiropractic Solutions, PLLC to furnish chiropractic therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

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Patient/Guardian Initials

**RELEASE OF INFORMATION**

I hereby authorize Creative Chiropractic Solutions, PLLC to release all information necessary (including photocopies of medical records) to secure reimbursement (see Notice of Privacy Practices).

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Patient/Guardian Initials

**NOTICE OF INFORMATION PRIVACY PRACTICES**

I have received and read a copy of HIPAA "Notice of Information Practices" from Creative Chiropractic Solutions, PLLC and I understand it completely.

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Patient/Guardian Initials

## NO SHOW AND CANCELLATION POLICY

At Creative Chiropractic Solutions, PLLC we strive to provide quick and timely service to all of our patients. In addition, we also provide evening and lunch hour appointments to accommodate work schedules.

**NO SHOWS:** Creative Chiropractic Solutions will charge a \$50 fee to all patients who “no show” to a scheduled therapy appointment. Any future appointments will be automatically cancelled. Patients will have to call to reschedule further appointments. Patients who “no show” to two (2) appointments will automatically be discharged from chiropractic care. A discharge note will be sent to the patient. It is up to the doctor’s discretion as to whether treatment will resume at a later date.

**CANCELLATION NOTICE:** In order to maintain our level of service, it is important that you provide us with 24 hour notice for cancellation of treatment appointments. This will enable us to fill your cancelled appointment spot with patients who may be on our waiting list. We understand that emergencies occur and will attempt to make reasonable accommodations.

Patient/Guardian Initials\_\_\_\_\_

## FINANCIAL POLICY STATEMENT

This is an Agreement between Creative Chiropractic Solutions, PLLC (creditor) and the Patient (debtor) named on this document. In this Agreement the words “you,” “your,” and “yours” mean the Patient (debtor). The word “account” means the account that has been established in your name to which charges are made and payments are credited. The words “we”, “us” and “our” refer to Creative Chiropractic Solutions, PLLC.

By executing this agreement, you agree to pay for all services and supplies that are received at time of service, except as specifically provided herein for Personal Injury, Motor Vehicle Accident or Workers Compensation claims.

You understand and agree that Creative Chiropractic Solutions, PLLC may, as a courtesy, assist you in making billing submissions for reimbursement to your insurance carrier, or may assist you in establishing payment and or credit facilities with other third party providers however this in no way and in no event relieves you of financial responsibility for your account.

You understand and agree that it is the patient’s responsibility to be aware of individual plans, policies, and benefits in regards to chiropractic care. You agree that an explanation of benefits from Creative Chiropractic Solutions staff does not guarantee payment from your insurance company, nor should it be considered a binding agreement of payment and/or benefits from your insurance company.

Patient/Guardian Initials\_\_\_\_\_

## OPEN ACCOUNT, ACCIDENT CLAIMS, WORKERS COMPENSATION CLAIMS

As a patient of Creative Chiropractic Solutions, you are responsible for the entire bill of services rendered should your insurance company deny payment for any reason or if you have no insurance. By signing this statement as a guarantor, you agree to pay for all services and/or supplies that are deemed patient responsibility by either Creative Chiropractic Solutions or other agency involved such as insurance, attorney, etc.

You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Creative Chiropractic Solutions, you will be responsible for all cost of collecting monies owed. If your account becomes past due, we may need to take necessary steps to collect this debt. This may include contacting the person listed as the Emergency Contact on your patient data sheet. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we refer your account to a collection agency, we will add a surcharge of 30% to your balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer’ fees which we incur plus all court costs.

**WORKERS COMPENSATION:** We require approval/ authorization by your workers compensation carrier prior to your initial visit for treatment resulting from an at work accident. Upon filing a worker’s compensation claim, there is a time period when your claim may be in deferred status. Chiropractic treatment may be provided to you during this time period causing incurred costs. After the deferred period, your claim may be accepted or denied. If your claim is accepted, we will bill your worker’s compensation carrier. If your claim is denied, we will bill your private medical insurance. If you do not have private medical insurance, the entire balance of your account is your responsibility. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or worker’s compensation carrier.

Patient/Guardian Initials\_\_\_\_\_

**PERSONAL INJURY/MOTOR VEHICLE ACCIDENTS (MVA):** If you are being treated as part of a personal injury lawsuit or claim, we may require verification, and we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill may be made by your attorney for charges incurred in a personal injury case. If you have Personal Injury Protection (PIP) through your motor vehicle insurance we will bill your insurance carrier and we will bill your private health insurance when your PIP benefits are used up.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**Required Payments:** Any co-payments or co-insurance required by an insurance company must be paid at the time of service. We shall have the right to make charges against your account at any time and require that visits must be paid at the time of service.

**Contracted Insurance:** If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible, or co-insurance, you must pay that at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. It is the insurance company that makes the final determination of payment and eligibility.

**Non Contracted Insurance:** Insurance is a contract between you and your insurance company. It is your responsibility to verify if our office is a contracted or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

**Billing Information:** It is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance of the account at the last date of service will be entirely patient responsibility. We will not be responsible for re-billing, appealing or other dealings with newly provided insurance company.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was paid by your insurance company or due by you. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve (12) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "past due balance" of your account. The "past due" balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. You understand that finance charges are not billable or payable by insurance.

**Waiver of Confidentiality:** If we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record. You agree to grant us a waiver of confidentiality if your account is submitted to an attorney or collection agency for non-payment.

Patient/Guardian Initials\_\_\_\_\_

## **NOTICE OF INFORMATION PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.**

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically this record contains your symptoms, examination, and test results, diagnoses, treatment, and a plan for future care or treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment.
- Means of communication among the health professionals participating in your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can certify that the services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information.

**UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS:** Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522).
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record (45 CFR 164.524).
- Request to amend your health record (45 CFR 164.528).
- Obtain an accounting of disclosure of your health information (45 CFR 164.528).
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**OUR RESPONSIBILITIES:** We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record.
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations.

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment. If you have questions and would like additional information, you may contact our Privacy officer at 610-722-0240, 1055 Westlakes Dr Suite 300, Berwyn, PA 19312. If you believe your privacy rights have been violated, you can file a complaint with the privacy officer or the Secretary of Health and Human Services. We will not retaliate if you file a complaint.

**EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS:**

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your health care team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent necessary to comply with workers compensation or other similar programs established by law.

Patient/Guardian Initials \_\_\_\_\_