Acknowledgement for Consent to use and Disclose of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your Protected Health Information will be used by Miami-Valley Spine+Joint, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- *You may request a restriction on the use or disclosure of your Protected Health Information.*
- *This office may or may not agree to restrict the use or disclosure of your Protected Health Information.*
- *If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.*

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____

Patient or Legally Authorized Individual Signature *Date*

_____

Print Patient's Full Name *Date*

_____

Witness Signature *Date*

Financial Policy

We are doing everything possible to hold down the cost of chiropractic care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

All payment is expected at time of service.

Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes co-payments and deductibles. We gladly accept cash, checks, or credit cards. There will be a 3% processing fee on all credit card payments for POS items.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

Those insured under Personal Injury Protection *(i.e. auto accidents)* or Workers' Compensation *(OBWC)*, are required to complete specific forms pertaining to their situation.

For those patients who have insurance coverage, we will be happy to fill out and submit claims at no additional charge. If our office is filing your insurance claims, payment in full is not required on the date of service, except if you have a deductible and/or copay. If, however, you choose to submit your own claims, payment in full is required at the time of service.

We will verify your chiropractic insurance benefits as a courtesy; however, it is not a guarantee of benefits. Those covered by general insurance are responsible for the patient portion *(i.e. deductibles, co-pays, etc.)* when services are rendered.

Insurance patients who neglect to supply our office with necessary information/forms within a reasonable amount of time will be responsible for payment in full.

For accounts past due, there will be mailings directly to the patient address regarding any account that is 30 days past due. Once an account gets 45 days past due, a 10% interest fee is then charged to the amount due on account; and every 30 days thereafter. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collection.

I agree that if MVSJ is unable to establish contact and have a lien signed with represented attorney/ auto insurer/ or health insurance, and/or does not have required Personal Injury/BWC paper work within one week from initial visit, patient is then responsible for paying portion of bill, minimum 25% of balance each visit; until established paper work is filed within the office. If patient is unable to provide any of the above documents within reasonable amount of time, then patient excepts responsibility for remaining balance in full.

I have read and understand the above stated financial policy. I agree to assign insurance benefits to the office whenever necessary.

Signature:_____Date of Birth:_____Today's Date: _____