

# CHIRO4SPORTS HIPAA COMPLIANCE

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

The patient identified above authorizes CHIRO4SPORTS to use and/or disclose protected health information in accordance with the following:

### **SPECIFIC AUTHORIZATIONS**

- I give CHIRO4SPORTS permission to use my address, phone numbers, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, and information about treatment alternatives or other health related information.
- I give CHIRO4SPORTS permission to share my testimonial, include my name on the "Congratulations/Thank you" board and display my picture.
- I give CHIRO4SPORTS permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving CHIRO4SPORTS permission to use and disclose your protected health information in accordance with the directives listed above.

### **EXPIRATION**

The Authorization shall expire on the following date: \_\_\_\_\_

### **RIGHT TO REVOKE AUTHORIZATION**

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of ChiropracticUSA. The written notice must contain the following information:

- Your name, social security number, and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until the Privacy Official receives it.

CHIRO4SPORTS requests this AUTHORIZATION for its own use/disclosure of PHI. (*Minimum necessary standards apply.*)

You have the right to refuse this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, ChiropracticUSA *will not refuse to provide treatment.*

You have the right to inspect or copy the Protected Health Information to be used/disclosed.

### **PLEASE FILL IN ALL AREAS IN BOLD**

\*\*\* A COPY OF THE SIGNED AUTHORIZATION CAN BE PROVIDED TO YOU\*\*\*

**Printed Name of Patient:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Signature of Patient/Guardian:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

\* \* \* \* \*

My signature acknowledges that I have received a copy of CHIRO4SPORTS' Notice of Privacy Practices:

**Signature of Patient/Guardian:** \_\_\_\_\_

## Office Policy

- Care Plan – We expect you to follow the plan that the doctor outlines for you in your third visit. Doing so ensures that you get the optimal results that we both desire. We are a corrective / wellness facility and we may not be able to accept you as a patient if you cannot follow the care plan. Your progress will be monitored closely with periodic examinations. There may be increased fees for office visits requiring an extraordinary amount of time such as with a new injury or additional treatments.
- Children – If you have children under the age of 18, it is our policy that they receive a subluxation check-up *at our expense* within the first 2 weeks of your care. As subluxation patterns run in families, we cannot in good conscience treat you for subluxation and leave your children to possibly develop the same subluxations present in your spine. If your children are not checked, we will have to discontinue your care until this occurs.
- Missed Appointments – If you need to change an appointment, you must make it up that week so the continuity of your care is not interrupted. Please notify us at least 30 minutes in advance if you cannot keep an appointment and reschedule it at that time. There is a \$10.00 “no call, no show” policy. The first time you will receive a warning, the second time your account will be charged \$10 to be paid before your next adjustment.
- Payment – Before service can be rendered it is essential that you are aware of the billing policies of this office. *Please take note of the following:*
  - A) All patients must pay at time of service if insurance coverage has not been confirmed and/or other arrangements have not been made. Insurance billing by this office is a service provided *only* to patients on *corrective care payment plans* or *personal injury cases*. Medical insurance will almost never cover 100% of chiropractic services; therefore any patient should expect to have some out of pocket cost.
  - B) Personal Injury (i.e. Auto Injury and Workers Compensation) patients must have:
    - 1) Name of insurance company responsible for the injury
    - 2) Valid claim number from the insurance company
    - 3) The adjuster’s name who is handling the claim for the insurance company
    - 4) A consent form assigning payment directly to Paradise Square Chiropractic Center**All four must be provided** before out of pocket expenses will be waived. If this information cannot be confirmed, you (the patient) will be required to pay at the time of service. Once confirmation has been made, we will return any fees paid and wait for insurance payments
  - C) Promotional offers, coupons, etc. – Patients coming in under promotions or special offers must understand that this reflects out of pocket cost whether or not you have insurance coverage. We will bill your insurance if applicable, as this notifies your insurance company of the services we will be providing.
  - D) Special Consideration – It is our policy to never turn anyone away from care based solely on financial reasons. Anyone wishing special consideration regarding fees must demonstrate three things:
    - 1) A sincere desire to regain his/her health
    - 2) A willingness to offer some sort of fair exchange for care
    - 3) *Real* financial hardship

I, \_\_\_\_\_, have carefully read and fully understand the above statements and accept chiropractic care on these terms.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_