PRENTICE Family CHIROPRACTIC LLC

PRIVACY AND FINANCIAL POLICIES

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use of disclosure of my protected health information (PHI) by Prentice Family Chiropractic, Dr. Steven Prentice, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that diagnosis or treatment of me by Dr. Prentice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment of healthcare operations in this office. Prentice Family Chiropractic is not required to agree to the restrictions I may request. However, if Prentice Family Chiropractic agrees to a restriction that I request, the restriction is binding.

I have the right to evoke this consent, in writing, at any time, except to the extent that Dr. Prentice has taken action in reliance on this consent.

I understand that I have the right to review Prentice Family Chiropractic's Notice of Privacy Practices prior to signing this document. Prentice Family Chiropractic's Notice Of Privacy Practices has been provided to me should I request a copy, and is also available in the reception area. This document also describes my rights and Prentice Family Chiropractic's duties with respect to my PHI. Prentice Family Chiropractic reserves the right to change the privacy practices that are described in the Notice Of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Financial Policy

1. It is the policy of this office that all services rendered are ultimately the patients responsibility.
2. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1 1/2 % per month.
3. Deductibles are considered unmet until documentation is received from the insurance company indicating that the deductible has been met.
4. All co-payments are payable per visit or at the end of each week. A $150 co-payment balance may not be exceeded by any patient.
5. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become payable in full, regardless of any claims submitted.
6. Filing of insurance claims is a courtesy we extend to our active patients only. We will not submit claims for inactive patients.
7. We will follow up on submitted claims to a reasonable degree but if an insurance company delays payment or does not pay your claim, you will be responsible for the outstanding balance and it will be up to you to get reimbursed.
8. Any special payment plans must be agreed to in advance of services rendered.

There will be a $3.00 fee for any claim re-billed due to insurance companies negligence or misplacement of a claim.

I understand and agree to the above conditions and policies

Signature: _____ Date: _____