CHIROPRACTIC ACUPUNCTURE HEALTH CENTER

2224 Cahaba Valley Drive Suite B3 Birmingham, AL 35242
Phone: 205-408-5600 Fax: 205-408-0797

PATIENT NAME: FIRST_____ LAST: _____
ADDRESS:_____CITY_____ZIP CODE:_____
EMAIL:_____BIRTHDATE: _____/_____/_____ PHONE: _____

CONSENT FOR CHIROPRACTIC AND ACUPUNCTURE SERVICES

As an established patient of Chiropractic Acupuncture Health Center (CAHC), I give consent to the doctors of CAHC to administer whatever therapeutic procedure of device as deemed necessary to treat my condition. I acknowledge that no guarantee of assurance of the results of treatment can be given to me by the above attending chiropractor, associate or assistant. And this consent will serves as blanket consent as long as I am an active patient of CAHC.
Signature: _____ Date: _____/_____/_____

BLANKET AUTHORIZATION AND ASSIGNMENT FOR ESTABLISHED PATIENTS

If insurance assignment is accepted, as long as I am an active patient with CAHC, I authorize release of all information regarding my condition to any Insurance Co., Attorney, or adjuster in order to process any claims for reimbursement and release you of any consequences thereof. I also assign and transfer to you the cause of action that exists in my favor, so that you may act in my behalf to resolve any insurance claim; and I direct any insurance plan or benefit obligated to reimburse me for covered services to make payment directly to the providers at CAHC. I understand and agree that health/accident/workers comp insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Johnson will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to be paid directly to Dr. Johnson will be credited to my account on receipt. However, I clearly understand that if I suspend or terminate my care and treatment, and fee for professional services rendered me will be immediately due and payable. If there are any issues with my appointment time, I will cancel or reschedule. For any missed appointment without notification, I will be charged a $25 missed appointment fee. Signature: _____ Date: _____/_____/_____

Due to the length of time it takes for insurance to send payment and because your insurance may not cover 100% of billable charges, a credit card **MUST** be on file with our office. We will automatically charge the card **through a Virtual Terminal by MOTO (after first notification)** due to the following: >>**Deductible and co-payments are not paid when services are rendered>>Patient terminates treatment plan>>Patient does not abide by payment plan agreement>>There has not been any payment made to an account within days>>Insurance does not cover all charges>>Insurance will not pay for services.** I understand that my credit card I have on file, will be run for services/products by terminal or virtual MOTO at CAHC, and I give consent to CAHC to run my credit card by **terminal** and **Virtual MOTO.** Signature: _____ Date: _____/_____/_____

I,_____, herby authorize Chiropractic Acupuncture Health Center to initiate debit/credit card charges and corrections to previous debit/credit card charges to my account, with the financial institution connected to my credit card for payment services/products rendered to me. If at any time, a card on file is stolen or lost, I will update this with CAHC at the time of the visit. I understand this office will run my credit card **Virtually by MOTO** with each service that I owe, unless otherwise noted to the clinic. These signatures will continue to apply to each and all terminal transactions through **CAHC** for one year. This authorization will remain in effect for one year. **CREDIT CARD(S)** on file:

1) (last four digits) ___ ___ ___ ___ Visa® MasterCard® Discover® EXP. Date _____/_____
2) (last four digits) ___ ___ ___ ___ Visa® MasterCard® Discover® EXP. Date _____/_____
3) (last four digits) ___ ___ ___ ___ Visa® MasterCard® Discover® EXP. Date _____/_____

Card Holder Name: _____ Signature:_____ Date: _____/_____/_____

I agree, that any credit or debit card charge made at or for CAHC clinic cannot be sent to any credit card company or bank for a dispute or fraudulent charges. I agree, that if any type of dispute or fraud charge is filed against CAHC, I will be charged a $50.00 fee for each visit disputed. From date of said $50.00 fee(s), I will have sixty (60) days to pay my balance in full of my account will be sent to collections. I agree, in order for CAHC to service my account or to collect monies I may owe, CAHC and our agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I have read this disclosure and agree that, **Chiropractic Acupuncture Health Center,** its **employees,** and/or **agents** may contact me/us as described above. Responsible Party Signature: _____Date: _____/_____/_____

CONSENT FOR EXAMINATION, X-RAY'S, CHIROPRACTIC SERVICE

1. I consent to have a complete examination performed to determine if my condition may be considered for my chiropractic care.
2. I agree and understand that if it is so determined, clinic policy mandates that x-rays be taken of the area of involvement so a complete study and analysis of the area can be made. I understand that all such x-ray films taken by this clinic or films ordered elsewhere for this clinic, whether or not paid for by the undersigned patient, shall become a part of this clinics professional records and shall be subject solely to the control and disposition of the clinic and their doctors. There will be a charge for copying x-rays if a request is made to transfer them to any other clinic or doctor by the patient or his representative.
3. I also give consent to the Doctors of Chiropractic Acupuncture Health Center, (CAHC), to administer whatever treatment or therapeutic procedure or device as deemed necessary to treat my condition.
4. I understand that the Doctors will go over my examination and x-ray results, during the follow-up appointment and explain the nature of condition, treatment recommendation, purpose of procedures, complication and risks, and allow time to answer any questions I might have. I acknowledge that no guarantee or assurance of the results of treatment can be given to me by the above attending Chiropractor, Associate or Assistants.

Patient Signature: _____ Date: _____/_____/_____

FOR FEMALES ONLY: To the best of my knowledge I am not pregnant and the Doctors of Chiropractic Acupuncture Health Center have my permission to x-ray me for diagnostic interpretation. _____ (Initial)
FOR MINORS ONLY: I hereby authorize the Doctors of Chiropractic Acupuncture Health Center to administer procedures, as outlined above, for my (indicate relationship) son/daughter/other. _____ (Initial)

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean: *Articles intended for the use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of Disease. A vitamin is not a drug, NEITHER is it a mineral, Trace Element, Enzyme, Amino Acid, Herb or Homeopathic Remedy.*
Although, a Vitamin, Mineral, Trace Element, Enzyme, Amino Acid, Herb, or Homeopathic Remedy may have an effect on the disease process or symptoms, this does not mean that it can be misinterpreted or classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular body symptom.
Nutritional counseling, vitamin recommendations, nutritional advice, or dietary advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patients diet in order to supply good nutrition supporting the physiological biochemical process of the human body.
Please acknowledge by signing below that you have read the aforementioned and understand that any nutritional recommendations given to you by this office are nutritional recommendations and dietary suggestions and are not for the treatment or care for any disease process that you may possess.
Patient Signature: _____ Date: _____/_____/_____

PRIVACY POLICY – NOTICE OF PRIVACY PRACTICES

This practice is required to provide our patients with notice of our privacy practices with respect to protected personal information collected from our office or website. We reserve the right to update, amend, or change this Privacy Policy at any time to conform to new laws and regulations or changes in business standards. This privacy policy does not extend to any third party companies or websites that link to or from our office or website and we are not responsible for any of the content affiliated with those outside companies or websites including social media. Those companies/websites have their own privacy policies and it is recommended that users read through them before providing information to the website owner. Wherever we collect sensitive information (such as credit card data or health history), that information is encrypted and transmitted to us in a secure way, such as the Secure Socket Layer (SSL) protocol. All forms have 256 bit encryption to securely transmit information. We take appropriate security measures to protect against unauthorized access to or unauthorized alteration, disclosure or destruction of data. These include internal reviews of our data collection, storage and processing practices and security measures, as well as physical security measures to guard against unauthorized access to systems where we store personal data. Our privacy policy does not cover content that is transmitted via email to our office. Email does not have the same encryption and security protocols and should not be used to transmit sensitive information. Our monthly newsletter service will be linked with the email address you put on file, you may remove your name from the newsletter list at any time. Please note that this Privacy Policy may change.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the use and/or disclosure of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for treatment and to carry out its health care operations. The Practice explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.
3. I understand and consent to the following appointment reminders or communications that will be used by the Practice:
    a. A postcard mailed to me at the address(es) provided by me; and
    b. Emails sent to me using the email address(es) provided by me; and
    c. Phone calls or text messages to my home, workplace or cell phone including voice messages on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this consent is valid for 7 years. I further understand that I have a right to revoke this Consent, in writing, at any time for all future transactions with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I do not sign this Consent evidencing my consent to the use and disclosure(s) described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Patient Name (Printed) Patient or Legal Representative* Signature

Date Signed: _____/_____/_____ Witness: _____ *Attorney-In-Fact, Parent or Guardian

Chiropractic services provided in this office are <u>payable the day services are rendered</u> unless other arrangement have been made *prior* to seeing the doctor.

1. Patient are personally responsible for all charges.
2. Assignment will be accepted on primary carrier insurance only. Claims will be billed electronically on a weekly basis. Receipts will be given to patients so they can bill their secondary carriers. The only exception to this is if Medicare crosses over to a Medicare supplemental policy electronically or If the secondary carrier is the only carrier that pays for Chiropractic Care; if not, the same rule applies. We do not accept assignment on third party liability claims, as they are non-assignable.
3. There will be a $25 minimum charge for medical records requested to liability carriers, attorneys, and insurance application requests. There will be a $5 charge for insurance claims forms that need to be completed that cannot be filed electronically and must be processed by hand or claims that have to be resubmitted more than twice.

Patient signature: _____ Date: _____/_____/_____

INSURANCE ASSIGNMENT POLICY

1. "Accepting Assignment" means billing the insurance company directly and waiting for the insurance company to pay us directly. We reserve the right to decide which insurance company we will accept assignment for.
2. All insurance companies recite a disclaimer upon verification of benefits stating that although they will give us the benefits under your policy, it is not a guarantee of payment. We cannot guarantee payment from an insurance company until we have received the payment in office.
3. Claims are billed from our office on a 7-day cycle. Insurance claim processing can take anywhere from two to five weeks. There is a Quality of Insurance law that states "clean claims" must be paid within 45 days. If we do not receive payment within that period of time, a tracer will be sent. If insurance does not pay within 90 days, you will be responsible for that balance.
4. You must pay your deductible, co-payment, co-insurance and/or any non-covered charges at time of service. We recommend contacting your insurance to find out what your deductible for chiropractic services are since it may be different than your deductible for other physicians and services.
5. Your co-pay, co-insurance, and/or deductible amounts are determined by the information we receive from verifying your benefits online or by telephone. Amounts collected from you are based on this estimate. This may not be the exact amount that your insurance will cover – it depends on what the insurance company allows, and what fees they consider reasonable and customary. Not all insurance companies pay the same, even for identical charges. The fees we charge are UCR and do not vary or change. Fees are only discounted if we are a provider for an insurance carrier, i.e. Medicare, and Blue Cross & Blue Shield. It is your responsibility to inquire as to whether or not we are a provider for your insurance carrier prior to services. At end of visit, service charges incurred are due and you will be responsible for your portion regardless of whether or not you knew we were a provider in your policy's network. We will file out of network but will not accept writeoffs.
6. <u>You are required to sign an Assignment Authorization form and any other documents that may be required by your insurance company on your initial office visit.</u> We cannot treat you before all paperwork is completed, nor can we treat you while someone else completes paperwork for you. We make our paperwork available online, so that your initial treatment can be as efficient as possible; you are informed that you may retrieve the paperwork from our website when you call to schedule your first appointment. Our office does not guarantee that your insurance will pay. We make every attempt to obtain accurate verification of benefits and coverage before you see the doctor on the initial visit. However, if your insurance claim is denied, you are responsible for the bill. Any balance due after insurance has paid, will be your responsibility also. **Also, if you have an insurance policy that requires a precertification before treatment, we will not be responsible if your claim is denied because a precertification was not received. We also inquire about the need for a precertification when we confirm your benefits over the phone. If we followed our office policy when checking for a precertification requirement and your insurance company still refuses to pay, that balance becomes your responsibility.** Your insurance coverage is a contract between you and the insurance company; it is your responsibility to know what a precertification is and when it is required. We will bill your insurance company as a courtesy. The information that we use for you is given to us by your insurance company. Your policy is a contract between you and the insurance carrier, and benefit information given to us is not a guarantee of payment. Any disagreement or inaccurate information provided to us by your insurance company or a misunderstanding of your coverage is between you and your insurance company, and you are still responsible for payment of services not covered or not paid by your insurance company. Any denied services will be your responsibility.
7. I understand and agree that health/accident/workmans comp insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Johnson will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to Dr. Johnson will be credited to my account upon receipt. **However, I clearly understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. I understand that any late fees incurred because of an overdue account are my responsibility. I also understand that if my account is 90 days past due with no payments made it will be turned over to collections and subject to a 50% collection fee from our office. The collections agency may also attach a collection fee, which I will also be responsible for. I understand that if for any reason my account is sent to small claims court as opposed to a collections agency, I will owe the 50% collection fee plus any reasonable attorney fees. I hereby waive my rights to exemption under the State of Alabama and any other state. I understand that any unpaid balance will be subject to a $5/week late fee charge after three statements have been mailed to me. Statements will be mailed to the address on my account. Any change of address that is not reported is my fault and I am still responsible for the late fees that have incurred due to non-received statements.**

Patient/Guardian signature: _____ Date: _____/_____/_____