ALARIE CHIROPRACTIC CENTER

514 North Line Street

Columbia City, IN 46725

# FINANCIAL OFFICE POLICY

1. All patients are on cash basis until our staff can verify their respective insurance coverage and deductible.
2. This office accepts cash, personal checks, debit cards and credit cards
3. **Out of state patients will be seen on a cash basis only. We will provide a bill for you to submit to your insurance company for reimbursement.**
4. Upon request, the office personnel will give you an estimate of the fees for services before they are performed and rendered; please remember that this is just an estimate and not a guarantee of benefits since each policy is different and your policy is an arrangement between you and your insurance carrier.
5. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
6. After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured/Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to doctor).
7. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
8. **As a patient, it is your responsibility to take care of the co-payment and any non-covered services. This office may make payment plan arrangements on an individual basis. Any such plan or arrangements should be made prior to your first treatment. Failure to make payments after 30 days of receipt of patient bill will result in a charge of 25% After 60 days of nonpayment, your account will be sent to collections resulting in an additional charge of 35%.**
9. This office will submit a claim ONE TIME, unless there is an error on our part. We will not enter into a dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claim will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. All insurance payments, regardless of which company issues a check first, are applied to your account, as any balance is due. If for any reason there is an over payment by your insurance company it will be entered in to our system and shall be credited to your account for future use. **We do not issue checks.**
11. If you receive any correspondence or checks from your insurance company, you agree to bring these to our office so we may determine if any action needs to be taken or if the check is on assignment to this office.
12. If the patient is referred to another specialist or discontinues care for any reason other then discharge by the doctor, the bill is due and payable in full immediately; regardless of any claims submitted.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If you have questions concerning this or any other matter, please speak to the receptionist prior to seeing the doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

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Patient’s Signature (or Responsible Party) Date

ALARIE CHIROPRACTIC CENTER

Focusing on the Wellness of You and Your Family

Dr. Renel Alarie

514 North Line Street

# Columbia City, Indiana 46725

(260) 244-6776

**Doctor’s Lien**

I, the undersigned, understand that all past, present and future bills incurred at the Alarie Chiropractic Center are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the Alarie Chiropractic Center having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any statement, claim, judgment, verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at the Alarie Chiropractic Center, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore, in consideration for the Alarie Chiropractic Center refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Alarie Chiropractic Center of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

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Patient’s Name (Please Print)

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Patient’s Signature

HIPAA Notice of Privacy Practices

Alarie Chiropractic Center

**Dr. Renel Alarie**

**514 North Line Street**

**Columbia City, IN 46725**

**(260) 244-6776**

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**1. Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law .

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: What might be over heard while being treated in our open treatment rooms: That your name may be seen on our sign in sheets: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_

ALARIE CHIROPRACTIC CENTER

Focusing on the Wellness of You and Your Family

**Consent To Care**

Every patient has the right to be informed of the risks of care prior to receiving care.

The following is Alarie Chiropractic Center’s consent for care. This consent covers the entire course of treatment for your current condition and any future conditions for which you may seek treatment at this facility.

The doctor will use his/her hands or a mechanical device to adjust/manipulate your joints. You may hear a “click” or “pop”, similar to when you “crack” a knuckle, and you may feel movement of the joint. Therapies, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, traction and/or exercise instruction **may** be used.

There are risks involved with any treatment performed by any health care provider. Chiropractic care is no exception. Although we take every precaution, **there are some risks** with chiropractic adjustments/manipulations. The risks range from non-existent to major. The risks involved in treatment to the spine **excluding the neck** are from least to most serious: muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral discs, nerves, or spinal cord (very rare). The risks involved in treatment **of the neck**

include any of the preceding, but also include the remote possibility of cerebrovascular injury, or stroke

(very rare: incident rate is one in ten million). Patients may experience stiffness or soreness after

the first few days of treatment (common). The use of heat or cold packs could produce skin

irritations, burns or other minor complications (rare).

**Other treatment options, not provided by this clinic, could include the following:**

Over-the-counter analgesics: These medications are known to cause irritations to the stomach,

liver and kidneys, and other side effects in a significant number of cases.

Anti-inflammatory drugs, tranquilizers and analgesics: These drugs can cause numerous undesirable effects, usually more serious than those listed above, and possible patient dependence in many cases.

Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which

include death), as well as an extensive recovery period.

**Risks of delaying treatment:**

Formation of adhesions, scar tissue and other degenerative changes may occur. These changes can reduce mobility and induce chronic pain.

Delay of treatment can complicate your condition, and make rehabilitation more difficult.

Please talk with Dr. Alarie if you have further questions or concerns. Dr. Alarie and his staff consider your health and safety a top priority. We will be happy to address any concerns you may have. We will only recommend care that we would feel comfortable having ourselves.

**I have read the explanation of chiropractic care described above. I had the opportunity to ask questions and have them answered to my satisfaction. I understand the risks and benefits of undergoing treatment and I freely choose to pursue the recommended treatment, and hereby give my full consent to treatment.**

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Printed Name

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Signature Date