Hartwell Chiropractic Financial and Privacy Policy

Assignment of Insurance Benefits:
I hereby authorize direct payment of my insurance benefits to Hartwell Chiropractic for services rendered to my dependents or me by the physician or under his-her supervision. I understand it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due. I understand that there may be an additional balance once insurance processes.
_____ **(initial)**

Payments:
I understand that payments are due in full at the time of service, unless I make prior arrangements with the billing department.
_____ **(initial)**

Missed Appointment Fees:
We have a 24 hour cancellation policy**.** Please call 24 hours before your scheduled time or you will incur a missed appointment fee. Our voicemail is on 24 hours a day, 7 days a week so you may cancel as soon as you are aware you will not be arriving to your appointment. We understand emergencies such as illness, deaths, car accidents, and weather issues (ice & snow happen). We will have flexibility for these types of situations. The fees are as follows: Missed Doctor Appointment: $25, Missed 30 minute massage: $25, Missed 45 minute massage: $30**,** Missed 60 minute massage: $35**,** Missed ND and Acupuncture Appointments for New/Established Patients: $50.

These fees are **patient responsibility**. These fees are not paid by insurance companies. If you have accumulated 3 missed appointment fees without payment, we will not accept future appointments with you until the balance is paid in full.
_____ **(initial)**

Privacy Policy:
I certify that I have received and read a copy of the Hartwell Chiropractic Patient Privacy Policy. I hereby authorize Hartwell Chiropractic to use or disclose information disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operation of this office.
You may request a restriction on the use or disclosure of your protected health information. 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. If you have any questions, please speak to Allie Stewart, Primary Privacy Officer, or Laurie Wilson, Office Manager and Compliance Officer.
_____**(initial)**

Notice of Treatment in Open or Common Areas
I understand that this clinic has a partially open rehab area; a private area will be made available upon request.
_____**(initial)**

I have read and I understand Hartwell Chiropractic Clinic's financial and privacy policies, and I responsibility for the payment of any fees associated with my care.

Patient Signature: _____ Date:_____

Print Patient's Full Name:_____

Witness Signature:_____

Updated 2/19/19