New Smyrna Beach Chiropractic Clinic, PLC Office Policies

Welcome to New Smyrna Beach Chiropractic Clinic, PLC - New Smyrna Beach Chiropractic Clinic would like to provide you with the best possible care. Dr. Prokop will conduct a thorough history and physical examination to decide if she can assist you. If Dr. Prokop does not believe that your condition will respond to chiropractic care, she will refer you to another health care provider, if appropriate.

Fee and Payment Policy - For all initial visits, payment is due in full at time of service. If New Smyrna Beach Chiropractic Clinic is contracted with your insurance company, payment is due in full until benefits can be verified, if allowable by your insurance company, and then any deductible and co-pay are due at time of visit. If New Smyrna Beach Chiropractic Clinic is not contracted with your insurance company, payment is due in full at time of visit. The office accepts cash (please try to have exact change), personal check and charge (Visa & MC). The office charges $25 for any returned check. If fees for service are not paid in a timely manner, a late payment penalty (ies) will be assessed. If you (the patient) do not pay your bill on a timely basis and the office must pursue collections efforts, you will be responsible for all fees associated with said collections. There is a $20 minimum for
credit card charges.

Credit Policy (For All Patients)
Accounts over 60 days old will receive a late fee of 1.5% per month with a minimum of $5.00 per month. All balances over 90 days must be paid immediately.

Cancellation Policy – Please notify the office as soon as possible if you will be unable to keep your appointment. Appointments not cancelled at least 24 hours in advance will be billed to the patient at the value of the visit missed and cannot be billed to, nor reimbursed by, insurance.

Payment Agreement
I (the patient/responsible party) understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges including charges for services not covered by my insurance company. I also understand that if New Smyrna Beach Chiropractic Clinic is not billing my insurance, I am responsible for all charges at the time of service.

Assignment of Benefits
I hereby assign and transfer to Amanda J. Prokop D.C., any and all causes of action that exist against my insurance company for unsatisfied medical billing. My attorney and /or insurance company are hereby requested and authorized to pay direct to Amanda J. Prokop D.C., any monies due to her on my account, the same to be deducted from any settlement made on my behalf. Further understand that I, the undersigned, agree to pay Amanda J. Prokop D.C. the full amount of her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company refuses to pay my claim.

Insurance
This office will process your insurance forms upon request if we are affiliated with your insurance carrier, otherwise we will provide you with the appropriate billing information to submit yourself. We will provide sufficient information to your carrier/you to obtain payment for your treatment. We have found that, in some instances, however insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full unless New Smyrna Beach Chiropractic Clinic is a part of your insurance plan and this is not allowed.

General Agreement
1. A copy of this form shall be as valid as the original.
2. I authorize the release of any medical information necessary to any third party requiring such information for the purpose of conveying credit to my account.
3. I permit this office to endorse remittances for the conveyance of credit to my account.
4. New Smyrna Beach Chiropractic Clinic, PLC has my permission to treat my minor children and me.

The following signature demonstrates an understanding and acceptance of the office policies of New Smyrna Beach Chiropractic Clinic, PLC.

______________________________ ______________
Practice Member/Guardian (if applicable) Signature Date

New Smyrna Beach Chiropractic Clinic reserves the right to change office policies as needed without notice.

NEW SMYRNA BEACH CHIROPRACTIC CLINIC, PLC
PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

__________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. New Smyrna Beach Chiropractic Clinic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for New Smyrna Beach Chiropractic Clinic to provide treatment to me, and also necessary for New Smyrna Beach Chiropractic Clinic to obtain payment for treatment and to carry out health care operations. New Smyrna Beach Chiropractic Clinic explained to me that the Privacy Notice will be available to me in the future at my request. New Smyrna Beach Chiropractic Clinic has further 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. New Smyrna Beach Chiropractic Clinic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders, communications from this office, birthday greetings, recall notice, billing statements and newsletters that will be used by New Smyrna Beach Chiropractic Clinic:

   a) a postcard or letter mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) emailing me at the email address provided by me.
4. New Smyrna Beach Chiropractic Clinic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for New Smyrna Beach Chiropractic Clinic to treat me and obtain payment for that treatment, and as necessary for New Smyrna Beach Chiropractic Clinic to conduct its specific health care operations.
5. I understand that I have a right to request that New Smyrna Beach Chiropractic Clinic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, New Smyrna Beach Chiropractic Clinic is not required to agree to any restrictions that I have requested. If Stern Chiropractic agrees to a requested restriction, then the restriction is binding on New Smyrna Beach Chiropractic Clinic.
6. I understand that this Consent is valid for seven years. I further understand that I have the 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 New Smyrna Beach Chiropractic Clinic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, New Smyrna Beach Chiropractic Clinic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then New Smyrna Beach Chiropractic Clinic 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.

______________________________ ______________________________
Name of Individual (Printed) Signature of Individual

______________________________ ______________________________
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):
Date Signed ____/____/____ Witness: ___________________________