

## STATEMENT OF FINANCIAL UNDERSTANDING

Patients with chiropractic insurance will be expected to pay any deductible or coinsurance amount they owe **on the date of service**. I understand that if there is a problem with my insurance I will pay Healing Arts Chiropractic, PC for any outstanding charges. Healing Arts Chiropractic, PC has no control over the payment of your claim by your insurance company.

If you do not carry insurance we ask that **all charges be paid at the time of service**.

Auto accident and workers compensation claims will be billed entirely to the insurance company. However, it is your responsibility to obtain the proper forms and notify your employer and or insurance company of the injury/accident. If the claim should be denied or rejected I understand that I'm responsible for payment of all charges.

### Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their own PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained for one time for all the subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your own security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures and our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with a privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient or authorize signature \_\_\_\_\_