OFFICE POLICY

FINANCIAL OBLIGATION:

I agree that I am financially responsible for payment of all amounts for services provided by 180 Health Medical and Wellness Center. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between 180 Health Medical and Wellness Center and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO) or Medicare, I understand that I am financially responsible for non-covered services or deductibles, co-pays or co-insurance as defined in my policy or plan. If the amount I am responsible for is not paid in full within (30) days of the receipt of the bill, I agree to pay interest at the legal rate as defined by Mo. Rev. Statute 408.020. I further agree to pay collection costs 40% of the principal debt and reasonable attorney fees and expenses. I agree to waive venue. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as interest, service fees, court costs, and attorney fees. Credit terms are liberally awarded to active patients and strictly enforced with inactive patients.

I understand 180 Health Medical and Wellness Center will provide routine and reasonable insurance claims processing to most carriers as a courtesy for me. In return, they expect cooperation from me, if necessary; to help collect any amounts due. I understand 180 Health Medical and Wellness Center reserves the right to refuse this courtesy or withdraw it at any time. I understand 180 Health Medical and Wellness Center charges for extraordinary processing such as reports, copies of records, etc.

It is understood and agreed that any amounts paid the doctor for x-rays are for examination only, the negatives will remain here as a property of this office as part of the permanent patient file.

I understand the doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Consent to Bill Insurance:

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is paid directly to this doctors office. I also understand that this amount will be credited directly to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Consent of Professional services and Release of Information:

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services he/she deems necessary in my case. I furthermore authorize him/her to disclose all or any part of my patient records to any person or corporation which is or may be liable under contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

_____ _____

Patient, parent if minor child, or guardian
Date

(If patient unable to sign, Representative name and relationship)

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 will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with 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 180 Health Medical and Wellness Center to use the PHI for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow his/her chiropractic office submit requested PHI to the Health Insurance Co. (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/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 PHI, however; our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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 security and right of privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in 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 our privacy official about an 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.
8. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at this time.
9. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
10. This notice is effective on the date stated below.

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

- Please list any person/persons that we are able to release information to. This information could include, but is not limited to scheduled appointment, financial, and or health information.

Family and Friends:		**Physicians, Insurances, &/or Attorney's:**
1.	**Relation:**	**1.**
2.	**Relation:**	**2.**
3.	**Relation:**	**3.**

Name (Signature) Date

Notice of Privacy Practices Acknowledgement

180 Health Medical and Wellness Center
1934 S. Glenstone
Springfield, MO 65804

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain right to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name or Legal Guardian (please print)

_____

Signature

_____

Date

Office use only

We have made the following attempt to obtain the patient's signature acknowledging the receipt of the Notice of Privacy Practices:

Date: _____
Attempt : _____
Staff Name: _____