Bratcher Injury & Wellness Center, P.A.

HIPAA Alternative Access Form

Patient Name_____ Date of Birth_____

Release of Information

I authorize the release of confidential communication of protected health information to be given to the following person/persons.

Spouse_____ Ph# _____

Child_____ Ph# _____

Child_____ Ph#_____

Other_____ Ph#_____

Relationship to patient_____

*The **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: My Home _____ My Cell_____

My Work_____

***If Unable to Reach Me You May:**

Leave a detailed message: Yes or No

Leave a message asking me to return your call: Yes or No

Do not leave a message other: _____

Signature_____ **Date:** _____

Acknowledgement of Review of Notice of Privacy Practices

I am aware of this office's **Notice of Privacy Practices,** which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient/Representative: _____

Date of Birth: _____ **Date:** _____

Printed Name: _____

Description of Representative's Authority: _____

_____

Employee Signature /Witness: _____

***If refusal to sign please state reason and document patient received a copy of the policy.**

_____

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Signature of Employee_____

Bratcher Injury & Wellness Center, P.A.

Financial Policy: Thank you for choosing Bratcher Injury & Wellness Center as your Chiropractic provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we provide as pertinent information prior to treatment.

Appointments: It is very important that your make every effort to keep your appointment. We try our best to allocate the proper amount of time for each patient. If you are unable to keep your scheduled appointment, please call to cancel so that we may open that time slot for another patient. We appreciate your effort to call us in advance to cancel.

Insurances: We have made arrangements with most insurance carriers and other health plans to accept assignment of benefits, because of this it is crucial to provide us with the correct insurance information. We will bill those insurance plans whom we have an agreement. **Copayments and deductibles are due at the time the services are rendered.** If your insurance changes it is **your** responsibility to inform our office and we will also need copies of your new insurance cards.

We gladly file your primary and secondary insurance as a courtesy to you. We extend this courtesy for a period of 45 days. If no payment has been received from them by that time, we ask that you contact your carrier regarding any claims that are past 45 days. We will continue to assist you in acquiring reimbursement. Please be aware that some of the services we provide may not be covered by your carrier and may not be considered reasonable and or necessary under the Medicare program and/or or other medical insurances; thus reimbursement is fully your responsibility.

Medicare Patients: If you have Medicare, please be aware that we are required by Medicare to collect deductibles and co-insurance from you when you do not have a secondary insurance coverage. Please furnish your Medicare & secondary insurance card to our receptionist.

Regarding unpaid bills over any applicable co-insurance or deductible: if you finalize a payment plan agreement with 30 days of receiving your first statement, these bills will not be subject to our policy of furnishing adverse information to consumer collection agencies regarding the amounts owed by the patient.

Private Pay Patients: Patients without health insurance will be charged a "time of service fee" and is required to be paid the same day services are rendered. Our practice reserves the right to charge 12% interest on any charges not paid by third party payers which are more than 60 days delinquent and any accounts over 180 days delinquent could possibly be turned over to an outside collection agency. If any unpaid balance should be transferred to the collection agency a 30% surcharge will be added to the unpaid balance.

Usual and Customary or Not Covered: Our practice is committed to providing you with the best treatment possible, and we charge what is usual and customary for our area. You are responsible for payment in full of any of any non-covered service regardless of an insurance company's arbitrary determination of usual and customary rates.

Regarding Referrals: If your insurance company requires a referral from you primary care physician (PCP) it is your responsibility to make sure our office has received it and that it is correct or you will be responsible for the complete charge. You may also reschedule your appointment until we receive it.

Dependent Patients: For all services rendered to a dependent patient, we will request the parent and or guardian to be responsible for all payments.

Medical Records Requests: A fee not to exceed $30.00 will be collected prior to researching and coping patient medical records. If more than 2 copies are requested of the medical record, there will be an additional per page fee beyond the $30.00 initial processing fee. Patients will be able to receive one copy at no charge, however any additional copies the medical record fee will apply.

Billing Inquiries: Please contact our office directly regarding any billing questions. If your account is past 180 days and has been entered into collections you will need to contact the collection agency regarding your account status.

Thank you for taking the time to read our financial policy. Please let us know if you have any questions or concerns as we want you to fully understand our policy.

_____ _____

Please Print Name of Patient or Responsible Party Date of Birth

_____ _____

Relationship to patient Date

_____ _____

Signature of Patient or Responsible Party Date