Spinal Care Chiropractic Center, P.C.

9303 Pinecroft, Suite 200
The Woodlands, Texas 77380
Phone (281) 292-6644 Fax (281) 298-1132

Clinic & Financial Policies

At **Spinal Care Chiropractic Center**, we strive to provide a nurturing and relaxing environment for all of our patients.

We hope that you have always found the clinic to be a place to rest and rejuvenate and we want to keep it that way.
Help us help you have a great experience!

Below are clinic policies we ask you to be considerate of when you come to visit us.

Clinic Policies:

Patient Privacy:
Due to the HIPAA Privacy and Security regulations, you may sign in or check out at the front desk, but otherwise you must be seated in the waiting area and not standing near or leaning on the front desk area. This is as much to protect your information as it is to protect others.

Cell Phones:
Cell phones must be turned off while on the clinic premises. When clipped to a belt or held, the cell phones interfere with the electro-stimulation machines used in therapy. It is also very disruptive to other patients if a cell phone rings or if someone is speaking on their phone while on therapy. If a call must be taken, we will remove the patient from therapy and ask that the call be taken outside. **There are no exceptions to this policy**, please understand that it is the only way to give all patients the opportunity to relax.

Children in the clinic:
We are a family practice and openly welcome the many families we treat on a regular basis. Your children are always welcome here however due to liability issues, we **ask that an adult MUST be with any child under the age of 6 years of age at all times**. Children must remain in the waiting area if they are not receiving treatment due to the potential for injury if wandering the therapy area unless they are being escorted to the restroom.

We appreciate your cooperation in adhering to these policies and look forward to keeping the clinic a place for everyone to enjoy and relax!

See Page 2 for Financial Policies…..

Financial Arrangements Policies:

Cash

Many payment options are available to make chiropractic care affordable. We will be happy to accept your personal check or any major credit card as payment at the time services are rendered. Additionally, payment plans may be available and should be discussed with your doctor.

Medical Insurance

Most medical health insurance includes some form of chiropractic benefits, however, policies vary widely. We will be glad to verify your insurance benefits as soon as possible with a copy of your health card. We will accept assignment on the majority of these policies, requiring you to only pay the portion not covered by your insurance. Once the policy benefits have been verified, we will inform you of the insurance coverage available and the amount you will be responsible for at each visit.

A Word About Insurance

Our doctors are dedicated to providing quality, affordable chiropractic care to as many patients as possible. We have set our fees reasonably so that you can afford our services and we can offer you the environment, staff, and quality of care you expect. Unfortunately, many insurance companies have arbitrarily determined their own “fee schedule” which may be more or less than our charges. We will work hard to assist you in collecting your insurance benefits when we accept assignment and wait for payment, but we also count on you for our final payment, not your insurance company. Any balance remaining unpaid after 60 days from submitting claims becomes your responsibility.

Auto Insurance Claims

In the event you are seeking treatment for an auto accident, insurance coverage may be available through **your personal auto insurance policy** (Personal Injury Protection-PIP). In most cases, **your auto policy** will cover your healthcare to a specific limit. Once this coverage is exhausted, you will be responsible for paying at the time of service. We will provide you with any necessary paperwork to file your claim with the third party insurance carrier once treatment is completed.

Please indicate below which payment option you prefer.

- ☐ Payment at the time of service
- ☐ Have the clinic take assignment on my insurance and complete all billing and paperwork. I understand I am responsible for any portion not paid by my insurance, including any unmet deductible and co-payments. I will pay these amounts at the time services are rendered.

I have read, understand, and agree to the above clinic and financial policies.

Patient Signature___________________________________**Date** _________________

SPINAL CARE CHIROPRACTIC CENTER
9303 Pinecroft, Suite 200
The Woodlands, Texas 77386
Phone (281) 292-6644 Fax (281) 298-1132

HEALTH CARE AUTHORIZATION FORM

Patient's Name: ____

Patient's SS#: _________________________________ DOB: ___________________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES SPINAL CARE CHIROPRACTIC CENTER TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Spinal Care Chiropractic Center to use my address, phone number and clinical records to contact me with birthday cards, holiday related cares and other health related information.

OPEN ROOM AUTHORIZATION

- I give Spinal Care Chiropractic Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor or another staff member at any time in private; the doctor will provide a room for these conversations.
- I further understand that most physical medicine modalities are provided in an open setting. If I do not authorize this treatment in an open room, the doctors will refer me to an out-patient physical therapy facility.
- By signing this form, you are giving Spinal Care Chiropractic Center permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: ______________________

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this **authorization,** in writing at any time. However, your written request to revoke this **authorization** is not effective to the extent that we have provided services or taken action in reliance to your **authorization.**

You may revoke this **authorization** by mailing or hand delivering a written notice to the Privacy Official of Spinal Care Chiropractic Center. The written notice must contain the following information:

Your name, social security number and date of birth;
A clear statement of your intent to revoke this authorization;
The date of your request; and
Your signature.

This revocation is not effective until it is received by the Privacy Official.

This **authorization** is requested by Spinal Care Chiropractic Center for its own use/disclosure of Personal Health Information. *(Minimum necessary standards apply.)*

You have the right to refuse to sign this **Authorization.** If you refuse to sign this **Authorization,** Spinal Care Chiropractic Center will not refuse to provide treatment; however, certain restrictions may apply.

You have the right to inspect or copy the PHI to be used/disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU**

PRINTED NAME

____

PATIENT SIGNATURE

____

DATE ____

SIGNATURE OF PERSONAL REPRESENTATIVE

____

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT:

____

Late for Your Appointment?

As our practice has grown, we need to set some new guidelines for those patients who are late for their appointment time. Late patients cause a back-up in therapy and thus longer wait times.

Our desire is for you to be seen quickly, not to have you wait for extended periods of time in the waiting room.

In order to accomplish this, we are asking that **if you are going to be 15 minutes late or more,** please **give us a call** and find out if we can still see you or if we will need to reschedule for another time.

Likewise**, if you show up to the office 15 minutes late or more without having called,** you may have to be **rescheduled for another day.**

Thank you for your help and understanding.

SIGNATURE: ______________________________________

Spinal Care Chiropractic Center, P.C.
9303 Pinecroft, Suite 200
The Woodlands, Texas 77380
Phone (281) 292-6644 Fax (281) 298-1132

Authorization for Treatment and Assignment of Benefits

I, ____ (patient/guardian) authorize **Spinal Care Chiropractic Center** and its staff to examine and provide treatment as they deem necessary.

I hereby authorize the release of any information concerning my health condition to any referring physician, insurance company, attorney or adjuster which is necessary and appropriate to complete a medical history or help in the processing of any claims. _____

I authorize and assign all payments for charges incurred through treatment at **Spinal Care Chiropractic Center,** whether from an insurance company or attorney to be made directly to **Spinal Care Chiropractic Center.** _____

In the event that any insurance company or attorney, obligated by contractual agreement, must make payment for charges incurred at **Spinal Care Chiropractic Center** directly to me, I agree to pay all charges in full and understand that I am responsible for all services rendered. _____

As a patient of **Spinal Care Chiropractic Center,** I am receiving treatment for injuries sustained in an accident on _______________________________________. I do not have an attorney representing me in this case, and I understand that all medical charges incurred as a result of this injury are not being paid until I settle this case with the insurance company. At that time, I agree to pay **Spinal Care Chiropractic Center** for all services rendered to me in relation to this injury. _____

_______________________________________ _____________________

Patient Signature **Date**

_______________________________________ _____________________

Witness **Date**

Spinal Care Chiropractic Center, P.C.
9303 Pinecroft, Suite 200
The Woodlands, Texas 77380
Phone (281) 292-6644 Fax (281) 298-1132

Information about your Radiographs & Medical Records

Medical Records & Radiographs maintained at this clinic in the course of your examination, diagnosis and treatment are the property of **Spinal Care Chiropractic Center** and will be maintained in this clinic as a part of your permanent record and patient file. If you should change doctors, or for any reason require this information, you may do any of the following:

For Medical Records:

1. Have the doctor of this clinic provide a verbal report at no charge by simply requesting your doctor to call our clinic.
2. You may request copies of your original medical records at a cost of $.50 cents per page.

For Example:

Pages	Cost	Pages	Cost
1-10 Pages	$5.00	31-40 Pages	$20.00
11-20 Pages	$10.00	41-Plus Pages	$25.00
21-30 Pages	$15.00		

***Note: We request that you give us 3 weeks to process copies of your complete medical records. Copies must be paid for in advance.**

For X-Rays:

1. Have the doctor of this clinic provide a verbal report at no charge by simply requesting your doctor to call our clinic.
2. You may request copies of your original x-rays be made at the cost of $10.00 per film.
3. You may check-out the original films with a signed release of records form. We request these films be returned to this office as quickly as possible.
   *** Note: Copying films takes approximately 5-7 days and must be paid for in advance. Generally, x-rays over 6 months old are not considered diagnostically current and most physicians will wish to take new films.**

Patient Signature______________________________ Date________________

____
Witness

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: **SPINAL CARE CHIROPRACTIC CENTER**
9303 Pinecroft, Suite 200
The Woodlands, Texas 77386
Phone (281) 292-6644 Fax (281) 298-1132

You are authorized to release *any and all* medical records, appointments and detailed receipts related to my medical condition and treatment that I may have had during the following time period listed immediately below:

Dates From: ____________________ to: ____________________

To the following person(s):

Name: ____ Relation: ________________________

Name: ____ Relation: ________________________

Name: ____ Relation: ________________________

Name: ____ Relation: ________________________

Name: ____ Relation: ________________________

Name: ____ Relation: ________________________

______ My initials here indicate that a photocopy of this authorization shall have the same force and effect as an original.

Date: ____________________

Patient Name: ____

Patient Signature: ____

Date of birth: ____________________ Phone Number: __________________________________

Witness Name: ____

Witness Signature: ____

SPINAL CARE CHIROPRACTIC CENTER
9303 Pinecroft, Suite 200
The Woodlands, Texas 77380
Phone (281) 292-6644 Fax (281) 298-1132

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

____________________________________ __________________
Patient Signature Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures

A. We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. *Example*: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

B. We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you while you are an inmate.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.

If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is
authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose your health information to a law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner or funeral director.

For research purposes.

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. You request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12-month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations;
Disclosures made to you;
Disclosures made in our facility directory;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials; and
Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

V. How to Contact Us

If you would like further information about our privacy practices, please contact:

Spinal Care Chiropractic Center
9303 Pinecroft, Suite 200
The Woodlands, TX 77380