Last Name: _____ First Name: _____ M.I. ____
DOB: _____ Cell: _____
Email: _____ Newsletter? Y or N
Address: _____
City: _____ State: _____ Zip: _____
How did you hear about Family Focus Chiropractic? _____
Would you like to receive reminders for future appointments? Y or N
If yes, please circle one. Text or Email

# Billing Policy

It is important that you understand that, as your health care provider our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. Please try to remember that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. Our office cannot be responsible for monitoring each contract exclusion or limitation.
3. There are some services done in this clinic that are not covered by most insurance companies, including Medica, Health Partners, and Medicare. They include: Nutrition Consultations, many blood tests (including the vitamin D test), Functional Medicine, and wellness or maintenance chiropractic care.
4. We will be happy to contact your insurance company to determine your benefits, however, any information our office gives you is an estimate based on the information available to us. Any changes in your coverage should be reported to Family Focus Chiropractic, LLC immediately.
5. Accounts that have patient balances due and there is no payment made for 60 days may be charged a $15 rebilling fee every month. It is our policy that any balances over 90 days may be turned over to a collection agency. You will also be responsible for any fees in the collection process. These overdue accounts would be reported to the credit bureau.
6. Appointments that are cancelled under 24 hours or missed for three consecutive times will result in a $55 charge that is due before the next appointment time.

I have read and agree to the above_____

# Notice of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

1. Disclosures of your protected health information without authorization are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. We will also send daily notes/records with medical billing, as necessary, to insure proper processing. We will disclose information for the purposes of treatment and practice operations as well. You may request restrictions on disclosures.
2. YOU AUTHORIZE FAMILY FOCUS CHIROPRACTIC LLC TO DISCUSS YOUR TREATMENT AND ACCOUNT WITH YOUR SPOUSE OR ANOTHER FAMILY MEMBER.
3. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
4. You may inspect and receive copies of your records within seven (7) days of a request. There may be a reasonable cost-based fee for photocopying, postage, and preparation. Electronic copies are available within 3 business days.
5. You may request changes to your records. Our practice has the right to accept or deny the request.
6. We maintain a history of protected health information disclosures that is accessible to you.
7. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
8. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations with the Office Manager.

I have read and agree to the above_____

# FAMILY FOCUS CHIROPRACTIC, LLC WILL BILL YOUR INSURANCE

I authorize payment of medical benefits to the physicians at Family Focus Chiropractic, LLC for services supplied to me. I also authorize the release of any medical information, or information necessary to process my claims.

_____ _____ _____
Print Patient Name Signature Date