ALIGN MED
Consent, Financial Policy and HIPAA

I consent to the performance of chiropractic adjustments and procedures including various methods of physical therapy, and if necessary, diagnostic x-rays on myself by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician(s) at Align Med and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with ALIGN Doctors and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that the practice of Chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

The patient must provide active proof of insurance at sign in. The patient understands that **they are financially responsible for all charges, whether or not paid by the insurance carrier.** Verification of benefits is not a guarantee that an insurance carrier will pay a claim. It is the patient's responsibility to know their coverage limits and rules of their insurance plan as well as their physician's active participation in the patient's particular plan. Please be aware that **insurance coverage is between the patient and the insurance carrier.** *Problems relating to a patient's coverage should be resolved between the patient and their insurance carrier.*

If payment is denied, the patient understands that they will be billed directly for services rendered, and the patient agrees to be fully responsible for payment within **90 days**. We will charge a fee of **$30.00** for any returned checks. We currently participate in a number of insurance plans, participation can and does change. We bill these companies for our patients and as a courtesy; we bill insurance companies that we do not have a contract with.

Patients are responsible for obtaining necessary referrals from another physician before their appointment. If the patient's insurance plan requires an authorization or referral to see a chiropractor, the patient must convey active and correct insurance information at sign in. If not, the patient may be responsible for the visit with the specialist.

Please update any necessary changes with the front desk, such as: change of address, phone numbers, e-mail address, etc., so we are able to get in contact with you if needed. Unpaid balances are processed for collection after 90 days without response on the account. **The patient agrees to pay all costs associated with collection procedures. (Initial here: ____________________) Co-pays and co-payment billing fees, cancellation fees, returned check fees, collection costs, records copying and form completion fees are not reimbursable by insurance.**

I, ___________________________________(Patient Name), hereby irrevocably assign and convey payment directly to Align Med as my designated authorized representative for injuries sustained on**___________________________.** All medical benefits and/or insurance reimbursement, and/or therapies rendered or provided by Align Med regardless of its network participation status should be paid directly to Align Med. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit. I hereby authorize Align Med to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Align Med any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Align Med or its attorneys in order to claim such medical benefits. A photocopy of this assignment is to be considered valid, the same as if it was the original.

______________________________ ____________________________________

Signature of Patient **Signature of Representative**

______/_______/_____________ ______/_______/___________
Date **Date**

ALIGN MED
Consent, Financial Policy and HIPAA

HIPAA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

______________________________ ______________________________
Name of Patient Birth Date

AUTHORIZES:

____
Name of Health Care Provider

____
Street Address, City, State, Zip Code

____
Phone/Fax Number

RELEASE TO:

____
Name of Health Care Provider

____
Street Address, City, State, Zip Code

____
Phone/Fax Number

Information to be released:

______ Office Visit ________ Procedure Reports _________ Entire Records ________ Billing _______ Consultations
_______ In Office X-Ray Images ________ Laboratory Results _________ Medications ________ Diagnostic Results _______Other

Purpose of disclosure:____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your rights with respect to this authorization:

1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "Authorizes" entity above.3) I understand a photocopy of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. 5) I understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of: Alcohol, Drug Abuse and/or Psychiatric records, Sexually Transmitted Disease and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information, or obtain copies of my health information, by contacting the Privacy Officer.

Expiration Date: This authorization is good until the following date(s) or for one year from the date signed.
I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Policies are subject to change without notice. I have read a copy of the Office Policies set forth by Align Med and authorize Align Med to bill my insurance, if applicable. I have read, or have had read to me, the above consent. By signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

______________________________ ______________________________

Print Patient's Name **Print Name of Representative**

______________________________ ______________________________

Signature of Patient **Signature of Representative**

______/_______/_____________ ______/_______/___________
Date **Date**