Excellence In Health Chiropractic

Dr. William A. Ross, D.C.

2008 E. Northern Lights Blvd., Anchorage, AK 99508 Phone (907) 562-6325 Fax (907) 569-5078

Name:_____ Birth date:_____ SS#:_____
Last First Middle Initial

Address:_____
City State Zip Code

Home Phone: (____)-_____ Cell: (____)-_____ Work: (____)-_____

Email Address:_____ Employer Name:_____ Phone:_____

Name of emergency contact:_____ Phone: (____)-_____

Which number may we call you at to confirm the appointments? HOME CELL WORK

Guarantor Information: If patient is a minor please fill in the following

Name: _____ Relationship to patient:_____

Address: _____
Only if different than our patient

Employer Name:_____ Phone:_____

In order to better serve you please list your primary doctor so that we can request pertinent health information.

Name of primary Doctor:_____ Phone:_____

Whom may we thank for referring you? (Circle one)

Anchorage Daily News
New Resident letter
Yellow Page
Professional (name)_____
Family (name)_____
Friend (name)_____
PPO List
Walk-in/Sign
Other_____

I authorize treatment for the patient named above. I understand that Excellence In Health Chiropractic will assist me in billing my insurance carrier. I also understand and agree that a copy of my insurance card will be given to the clinic. I also understand that my insurance policy is an arrangement between the insurance carrier and me. I understand and agree I am ultimately responsible for the balance of my account for any professional services rendered (regardless of my insurance status). I certify this information is true and correct to the best of my knowledge. I will notify Excellence In Health Chiropractic of any changes in my status or the above information.

Patient signature:_____ Date:_____

Guarantor signature:_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the the Notice of Privacy Practices of Excellence in Health Chiropractic and Rehab, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ Date

_____ Signature

_____ Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

- ☐ Personally ☐ Mail ☐ Phone Follow Up
- ☐ Other: _____

_____ Date

_____ Signature

_____ Print Name of Physician

Excellence in Health Chiropractic and Rehab
Name of Practice

Excellence in Health Chiropractic & Rehab Clinic
William A Ross D. C.

FINANCIAL POLICY

Thank you for choosing Excellence in Health Chiropractic & Rehab Clinic. It is our commitment to make your chiropractic and physical therapy needs a success. To better serve your financial needs, our office offers several methods of payment. Please choose the plan that suits you. Patients who are here for their first visit are expected to pay in full unless prior arrangements have been made with the billing department. We are happy to answer any questions you have regarding our fees.

Please check one of the following plans:

_____ **Cash/Check/Credit Card***: Fees are to be paid at the time services are rendered unless special arrangements have been made in advance.

_____ **Workers' Compensation***: We will bill your employer's workers' compensation insurance company directly. We require all insurance information, including claim number, within 3 days after your first appointment.

_____ **Auto Accident***: ***A co-pay of $10 is required for each visit and reimbursable once the claim has been settled.*** We are willing to work with your lawyer or bill the insurance company directly. You will need to provide all claim numbers and billing information within 3 days after your first appointment.

_____ **Private Insurance***: As a courtesy to our patients, we will bill your insurance company once you have met your annual deductible. You are responsible for **co-payments** and for any **non-covered services** at the time of your visit.

- A 12% per annum will be applied to unpaid balances that are over 90 days.

Cancellation Policy

Appointments can be re-scheduled or cancelled free of charge if we are notified at least 12 hours before your scheduled appointment. Cancellations or missed appointments will be subject to a $20 administrative fee if the 12 hour notice was not given. Cancelled or missed massage therapy appointments will be subject to a $20 cancellation fee for 30 minute massages, $30 cancellation fee for 45 minute massages, and $40 cancellation fee for 60 minute massages. Insurance will not be billed for this charge.

Financial Agreement

* I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
* I have read the policies above and understand them.
* I understand I am financially responsible for all charges, whether or not they are covered by my insurance company.
* I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.
* I authorize and request payment of medical benefits directly to my provider.
* I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
* I understand that charges may occasionally be added or modified by my clinician.
* I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date. Should legal action be taken by this office to collect an unpaid balance due for medical services provided, I/we agree to pay reasonable attorney's fees or other such cost as the Court determines proper.

**A photocopy of this Assignment shall be considered as effective and valid as the original.*

I understand and agree to this Financial & Cancellation Policy:

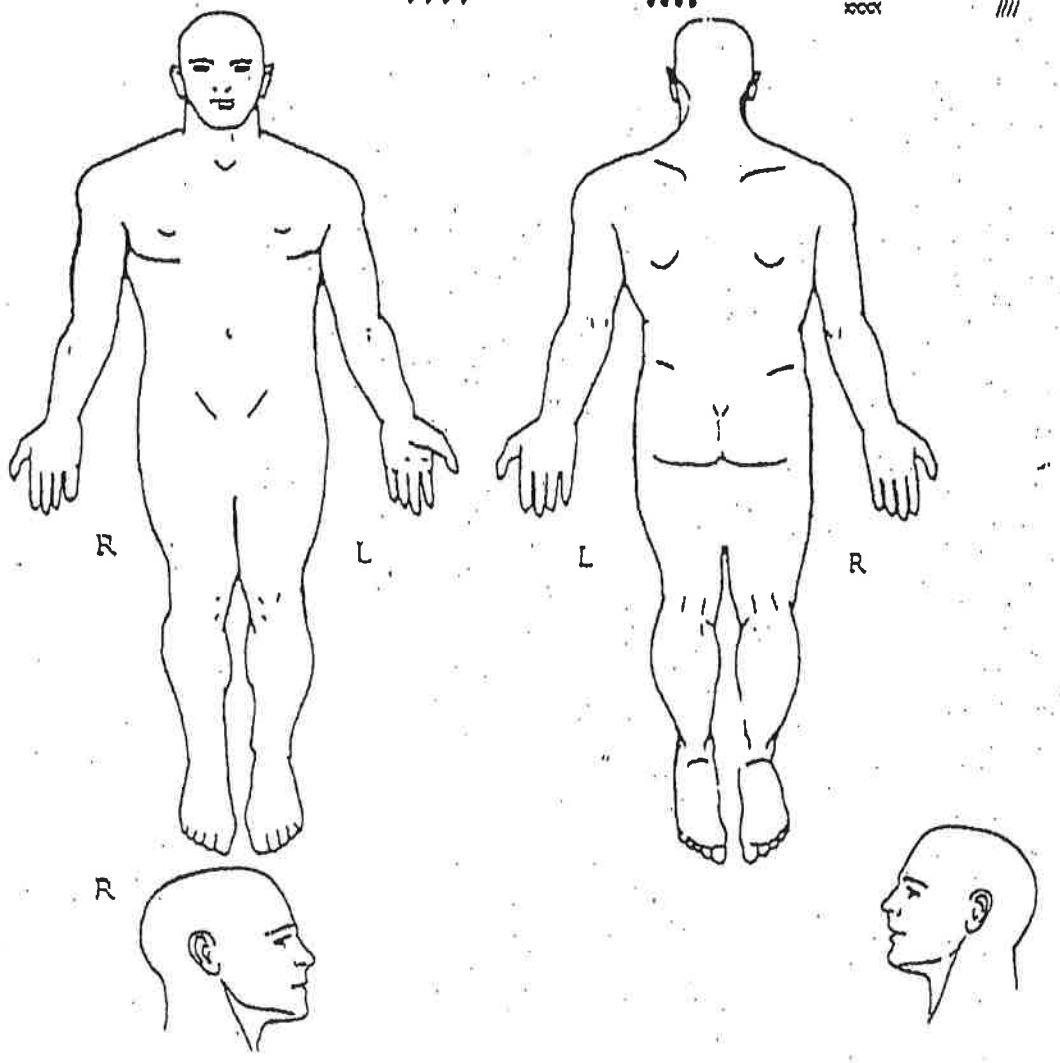
Patient Signature :_____ Date_____

Guarantor Signature _____ Date_____

Revised 11.30.2010

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.

Numbness Pins & Needles Aching Cramping Burning Stabbing



Name:

Date:

NOTICE OF PRIVACY PRACTICES

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.

EFFECTIVE: September 23, 2015

We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We are required to follow the practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time. If we change our notice, we will post the revised notice in the facility and will have them available upon request. You can receive a copy of the current notice at any time. This Notice describes how we have extended certain protections to your PHI and how, when, and why we may use and disclosure your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. To the extent there is stricter State or federal law regulating the privacy of your PHI, we will comply with the more strict provisions of law.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We are committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

Treatment. We may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

Payment. We may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

Health care operations. We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations as permitted by law.

Business Associates. It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Treatment Alternatives. We may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Individuals Involved in Your Care or Payment of Your Care. We may, subject to specific limitations, disclose your PHI to friends or family involved in or who help pay for your health care.

As Required by Law. We will disclose your PHI when required to do so by federal, state or local law.

Appointments, Services and Fundraising. We may contact you to provide appointment reminder, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such confidential communication by sending your written request to the Privacy Officer. We may contact you to support our fundraising efforts. You may opt-out of receiving any further fundraising communications from our facility by notifying our Privacy Officer at (419) 474-1002, in writing of your name, address, and request to be removed from our fundraising mailing and contact lists.

THE FOLLOWING USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR AUTHORIZATION: (i) uses and disclosures for marketing purposes; (ii) uses and disclosures that constitute the sale of protected health information; (iii) uses and disclosures of psychotherapy notes; and (iv) other uses and disclosures not described in this notice.

SPECIAL USE AND DISCLOSURE SITUATIONS

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, accrediting

organizations such as The Joint Commission, required abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donations, worker's compensation purposes, and emergencies.

We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

We may use or disclose your medical information for research purposes but only with your prior authorization or a proper waiver of authorization from an IRB or Privacy Board.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request that we restrict how we use and disclosure your health information. These restrictions must be made in writing to our Privacy Officer and signed by you or your representative. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.

Access to Individual Health Information. You have the right to inspect and copy your health information. All such requests must be made in writing to our Privacy Officer and signed by you or your representative. We must make PHI available in electronic format upon request and where available. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendments to Individual Health Information. You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases, we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the Privacy Officer.

Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Officer. The first accounting in any 12-month period is free; you will be charged a reasonable fee for each subsequent accounting within the same twelve-month period. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Notification of Breach. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your PHI.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this or any revised Notice and/or an electronic copy by email upon request to the Privacy Officer.

Right to File a Complaint. If you believe that we may have violated your privacy rights, or you disagree with a decision we about access to your PHI, you may file a complaint with the Privacy Officer listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. There will be no retaliation for filing a complaint.

Right to provide an authorization for other uses and disclosures. We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Contact: Privacy Officer

If you have questions about this Notice or any complaints about our privacy practices, please contact our privacy officer at 5606 Secor Rd., Toledo, OH 43623 or 419-474-1002.

A COPY OF THIS NOTICE OF PRIVACY PRACTICES WILL BE MADE AVAILABLE UPON REQUEST.