HARTMAN CHIROPRACTIC CENTRE
OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits not included in your treatment plan will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.

3. We accept assignment as a courtesy to you; you are responsible for you entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

4. Whenever you receive any correspondence from your insurance company besides your explanation of benefits, please bring this information into this office as soon as possible. If you should receive a check from our insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment must be made in full immediately; regardless of any claims submitted.

8. If you have questions concerning this or any other matter, please speak with the office manager prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient Signature:_____ Date: _____

PATIENT HEALTH INFORMATION CONSENT FORM

DR. MICHAEL C. HARTMAN, HARTMAN CHIROPRACTIC CENTRE

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you read the HIPPA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to minimum needed for what the insurance companies require for payment.
2. The patient had the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given in the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for care given prior to the written request to revoke consent, but would apply to any care given after the request had been presented.
5. For your security and right to privacy, all staff has been trained in area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all the precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of patient (please print):_____Date: _____

Patient Signature _____

This PHI consent will be part of your medical record at this facility