The OM Center

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HIPAA/ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION updated 1-1-23

I acknowledge that I have received from **The OM Center for Well Being** a *Notice of Privacy Practices* for protected health information to review

Documentation of Good Faith Effort to Obtain Written Acknowledgment

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that applies):

- ✓ Showing the patient, the Notice of Privacy Practices posted in our office.
- ❑ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ❑ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ❑ The patient refused to sign because he/she did not understand the form.
- ✓ Asking the patient to sign this Acknowledgment form.

●____________I give permission to share my health information with my primary care physician

(PCP NAME): ____

Phone:________________________________Fax:__________________________

●__________I give permission to share my health information with my referring physician

(NAME(s))____

Phone:________________________________Fax:__________________________

●__________I give permission to the OM Center to allow the following (family member, spouse, friend, etc.) (NAME): ____ to access my health information, access my records, and I give permission to this person to make changes to my appointments. I understand that I still remain responsible for any changes made or charges accrued.

Relationship to patient: ____

Patient Signature________________________________Date _______________

CANCELLATION POLICY (Insurance or self-pay)

Doctor Visits:

Should a patient no call, no show OR repeatedly cancel appointments with less than 24 hours' notice they will be subject to a $25 cancellation fee for follow-ups and a $50 fee for exams. (Note: Monday appts must be canceled Sat. by 1pm.)

Manual Therapy and Yoga Cancellation policy:

Please consider your therapist is paid by the work they are ***scheduled*** to perform. If you cannot make your appointment or need to reschedule, please do so 24 hours before your session. Failure to do so will result in a $60 cancellation/no show fee as The OM Center must still pay the therapist for their time. Emergencies are considered. I understand the above cancellation policy. (Note: Monday appts must be canceled Sat. by 1pm.)

If you no show for any appointment and do not call, your card on file will automatically be charged.

Patient Signature________________________________Date _______________

PATIENT INFORMED CONSENT FOR TREATMENT BY THE PHYSCIAN

I hereby request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical medicine and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic and/or other licensed Doctor of Chiropractic who now or in the future work at this clinic.

I have been provided an opportunity to discuss to my satisfaction with the Doctor of Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures or have waived my desire to do so. I understand that results are not guaranteed. I have also been advised of alternatives to chiropractic care and have had all questions and concerns pertaining to the alternatives addressed to my satisfaction.

I understand and am informed that, as in the practice of medicine, the practice of chiropractic has some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, strains and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise his/her clinical judgment during the course of care to determine what procedure(s) are necessary at the time (based upon the facts known to him/her) that is in my best interest to address my condition(s).

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_______________________________Date _______________

PATIENT INFORMED CONSENT FOR TREATMENT BY THE THERAPIST

Yoga Rehab and Manual Therapy details:

Should you desire manual therapies (i.e. medical massage/therapeutic activities/therapeutic exercises) as part of your care-plan to help you reach your health goals, this agreement is to help you understand what this entails and your responsibilities.

If the doctor prescribes manual therapy, your therapist will be provided instructions by the doctor. Your session may include exercises, stretching; trigger point therapy, myofascial release, other manual techniques, and home education. Please be sure to communicate with the therapist if you are uncomfortable for any reason or if the pressure is too hard or too light, or anything else you deem helpful. If there are any new injuries, new conditions or a change in medications since your last visit, you must inform us of such changes ***before*** treatment begins. Sessions are scheduled in 30 and 60-minute segments. This includes time for the therapist to review your intake and ask any relevant questions, as well as time for you to undress and redress following the treatment. Because sessions are scheduled back to back, it's important you are on time for your session. If you are late, your session may be shortened or canceled.

Patient Signature_______________________________Date _______________

Out of Network Insurance Assignment Policy and Agreement

Your insurer uses a third-party payer/administrator for its chiropractic care in some or all of its plans. Unfortunately, we are not in network with this third party. Accordingly, your benefits are available thru your “out of network” benefits.

You have a $______ deductible on your out of network benefits. To date, your insurers website shows $______ remains to be met. This figure may be lower if you have recently been treated by other medical providers.

This means you must pay this deductible amount before your insurance will cover your care. When you have met your deductible, you will be responsible for a ____ coinsurance. That is roughly $____ a visit.

We will submit your claims to your provider. Until your deductible is met, our office policy is to collect $60 per visit ***toward*** the fees. You will get a balance bill monthly for the remainder of charges once your insurer has processed your claims. Collecting $60 simply helps prevent you getting a large bill all at once.

If you have an unusually high deductible, which you don’t believe you will meet, it may make more sense for you to avoid using your insurance and opt to be seen as a cash patient. Cash rates are legally discounted as we don’t have administrative costs of filing with insurance. **All fees are due at the time of service** and you are given an approximate 15% time-of-service discount. The cash fee schedule is attached.

You are able to use your flex spending/medical savings account for cash services and should you choose to do that we will provide receipts with documentation.

I, ________________, acknowledge I have read and understand the above-noted policy and that any questions I have were answered.

(CHOOSE ONE)

_______ I opt to submit to my insurance

_______ I opt to not submit to my insurance and to do the discounted self-pay rate.

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We will do our best to accurately verify and file your insurance for services, however, benefits quoted by your insurance carrier are not a guarantee of payment. All current insurance information must be provided at the time of service, including any information relating to any open **worker's compensation** or **personal injury cases**. You are responsible for all copays, co-insurance, deductible and non-covered services on the day services are rendered.

________**If you have a primary and secondary insurance,** you must provide both policies and clarify which is ***primary***. Failure to do so could result in retraction of payment by your insurer. If this happens it will be your responsibility to correct this with your insurers, and if not corrected you will be responsible for payment of the retracted amounts.

If your insurance denies any service for any reason, you will be responsible for full payment for services provided by us. This does include denial of payment as a result of providing the clinic with inaccurate insurance information. You may pursue reimbursement directly from your insurance company that you deem payable.

Unpaid Balance

You will receive monthly statements for any unpaid balances. Payment is due within 30 days of receipt. We will make every effort to work with you to resolve any outstanding balance should you be experiencing financial difficulty. **Failure to pay or address your balance within 30 days may result in collection and additional fees. We also reserve the right to charge any credit card on file for any fees that are 90 days past due.**

Signature and Agreement

With my signature below, I confirm that I have been informed of and understand the above outlined policies. I authorize The OM Center to act as my agent submitting my insurance claims and I authorize payment of these benefits directly to The OM Center on my behalf for all services. I authorize any holder of my medical information to release information needed to determine benefits payable for rendered services. If I have additional insurance, my signature authorizes release of my medical information to any insurer agency I have given and authorizes my doctor to act as my legal agent. If my insurance does not cover any portion of this visit, I further acknowledge that I am responsible for payment of these services. Unless revoked by me in writing, this authorization is effective for my lifetime.

Date ____________

Relationship to patient_____________________

Patient/ Legal Guardian signature _____________________