Forest Park Chiropractic

& Acupuncture

Dr. Reed Moeller, Chiropractic Physician

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustment or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injures to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the natures, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction and I also understand that specific results are not guaranteed.

It there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Representative (if patient is a minor or is handicapped) Date

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1250 W. Kemper Rd.
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HIPAA PATIENT AUTHORIZATION

This notice describes how chiropractic and medical information about you may be used and disclosed and how can get access to this information. Please review carefully.

In the course of your care at Forest Park Chiropractic and Acupuncture, we may disclose personal and health related information about you in the following ways:

- Your personal health information, including your personal records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnostic, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, attorney, an HMO, a PPO, or in workers' compensation cases your employer, if they are responsible for the payment of your services.
- Your name, address, phone number, and health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home/work to receive an appointment reminder, a message may be left. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care you are you are provided or the reimbursement avenues associated with your care, however, full payment will be expected at the time of service.

Under federal law, we are permitted or required to use or disclose your health information without your consent or authorization in these following circumstances.

- If we are providing health care services based on the orders of another health care provider.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicate with you, but I our professional judgment we believe that you intended for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your of potential your health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your healthcare to you personally at the time you receive your care from us.

We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for 10 years from the date the record was created or as long as the information remains in out files. In addition, you have the right to request an amendment to your health information.

Requests to inspect, copy, or amend your health related information should be submitted to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein.

We are also required to provide you with this notice of privacy practice with respect to your health information.

We are further required by law to abide to the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. We will notify you in writing as soon as possible for the following changes. Any changes in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to a re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any other aspect of our privacy activities, or if you would like additional information regarding our privacy policies, please contact Dr. Moeller.

This notice is in effect as of this date. This notice, and any alterations or amendments made hereto will expire ten years after the date upon which the record was created. My signature acknowledges that I understand the privacy practices and I have the opportunity to receive a copy of this notice.

Print Name_____ Signature_____ Date_____

If you are a minor, or if you are being represented by another party:

Other Party/Parent Print name_____ Signature_____

Financial Policy of
Forest Park Chiropractic & Acupuncture
1250 W Kemper Road
Cincinnati, OH 45240 USA

It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

• All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $200 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.

• For your convenience, this office accepts cash, checks, and the following credit cards:
Visa, MasterCard, American Express, Discover

• This office participates in a discount medical plan organization (DMPO) and offers discounted fees to uninsured, underinsured, or partially insured patients who are members. We will assist you in learning more about this should you wish to access these discounted fees.

• Should payment be refused by your bank for any check written, this office will charge a fee of $35 to offset the charges we will incur as a result of the returned check.

• As a courtesy to our patients, this office will bill third party payers in which we are in network with, accept assignment, and wait to be paid for some portion of our patients' financial responsibility. For those third party payers in which we are out of network, we will provide a superbill for your convenience.

• The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "cash" patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.

• No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.

• If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 90 days the balance becomes due and payable immediately and your assignment is revoked.

• All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness or supportive care.

• Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

Signed: _____ Date: _____

Witness: _____ Date: _____