Patient's Name: _______________________________________ Patient #: ________________

Financial Policies for Insurance

I understand and agree that I am ultimately personally responsible for payment of all services rendered to me and I am responsible for any costs, consisting of court, collection and attorney fees if a collection procedure is necessary to satisfy my bill. Returned checks are subject to a fee of what the bank charges this office.

Financial Policies for Self-Pay

I understand and agree that I will pay the required fee at the time of service.
ACSC has the right to refuse treatment due to any outstanding balance that has not been paid.

Authorization for Payment to Provider of Care

I authorize/request my insurance company or attorney to pay directly to Alabama Chiropractic & Spine Care (ACSC) the expense benefits allowable and payable to me under my current policy or settlement, as payment toward the total charges for services rendered. I agree that this office be given limited power of attorney to sign my name on any drafts for payment of my bill. I understand and agree that insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. In some cases, payment may be expected at the time of service including co-payments, deductible and fees for non-covered services.

Authorization to Release Medical Information

During your care at ACSC, we may use or disclose your PHI (Protected Health Information) in the following ways:

- We may disclose and discuss your PHI to your designated emergency contact, primary care physician, referring physician or any other health care provider if it is necessary to refer you to them for further diagnosis, assessment or treatment of your health.
- We may disclose your PHI and billing records to another party if they are potentially responsible for the payment of your services.
- Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about your present care and account balance.
- We may leave a message, send a text, mail, or email to all communication outlets you have given us.

Privacy Notice

The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your PHI is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your PHI, please inform our office.

I have read, understand, and agree to this consent form.

_________________________________ ________________

Patient/Guardian Signature Date