Consent for Use or Disclosure of Heath Information/ Marketing Authorization

Our Privacy Pledge. We are very concerned about protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We must disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- **We may use your name and/or pictures in any marketing, advertising, or patient education material including, but not limited to, testimonials, brochures, flyers, social media.**

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in this notice. If we make a change to our privacy practices, we will notify you in writing when you come in for services or by mail. Please feel free to contact us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures. You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have the ability to request and receive a copy of this notice at any time.

_____ _____

Client Name Printed Authorized Provider Representative

_____ _____

Signature/ Parent Signature Date

ROSHAU CHIROPRATIC & REJUV WELLNESS CENTER OFFICE'S FINANCIAL POLICY

Thank you for choosing us to serve you. Our office requires that you read and sign this form prior to care rendered.

As a courtesy, we file insurance claims for Blue Cross Blue Shield, Sanford, Medicare, Auto Accidents and Personal Injury. Except for Medicare, any secondary insurance that needs.
to be filed will be the patient's responsibility. ***WE DO NOT FILE FOR ANY OTHER INSURANCE COMPANY.*** You may obtain a copy of services performed to submit directly to your health insurance provider.

This office has chosen to be a *NON-PARTICIPANT* with Medicare, Blue Cross Blue Shield, and any other insurance company. This office does not guarantee that any insurance company will pay, nor does this office guarantee that any insurance company will or should pay for the fees as charged. **Medicare** will pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under the Medicare Program Standard, Medicare will deny payment for that service. Medicare may also deny your care for any reason they deem necessary.

We do not accept assignment; therefore, any insurance checks are sent directly to the patient. The patient is responsible for payment *IN FULL* at the time of the visit, regardless of any insurance company's determination of usual and customary rates. If payment is made to the provider, this office chooses how to process the payment; if there is a balance on the account, it will automatically be applied to the account. If there is no account balance, payment will be reimbursed to the policyholder/ patient.

Unless due to auto accident, personal injury insurance, or other arrangements are made in advance, **we require that patients pay 100% of charges at the time when services are rendered**. You are not allowed to owe the office more than $150 at any given time, or your privilege of being a client in this wellness center may be terminated.

Patients that come into this office as personal injury and auto accident will be held responsible for any charges that the insurance company does not pay. If an attorney is handling your case, notify us immediately. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active client. If outstanding charges exceed a 2-month period with no payment from your insurance company, you will be responsible for payment in full at that time. If/when the insurance company reimburses this office for the charges you have paid for, we will reimburse that amount to you. If you suspend or terminate care, any fees for services are due immediately.

Patients have the option to sign up for our Wellness Plan Program. The purpose of this program is to provide an **affordable, all-inclusive program of corrective chiropractic care** with the goal of spinal correction/stabilization and wellness care with substantial savings. If interested in this, please notify one of our team members for more information**!**

WE ACCEPT CASH, CHECK, AND VISA/ DISCOVER/ MASTERCARD/ AMERICAN EXPRESS

I, the undersigned, HAVE READ THIS OFFICE/ FINANCIAL POLICY AND AGREE TO ITS TERMS.

_____ _____

Patient/ Parent Signature Date