WELCOME!

The following information is to help you understand the payment requirements at Amarillo Family Chiropractic:

HEALTH INSURANCE

When filing your health insurance, please let the front office know. A copy of your card will be requested. We file insurance as a courtesy to our patients. Our insurance department will call and verify your benefits. **Verification of eligibilities may not guarantee benefits**. You as a patient are responsible to see all aspects of your claims are filed correctly. **The patient is responsible for charges not paid by the insurance. Any/all co-pays and/or personal portions will be due at the time services are rendered.**

Patient authorizes the Doctor to deposit checks received on Patient's account when made out to the Patient.

Failure to comply with payment agreements will result in Amarillo Family Chiropractic forwarding your account, along with any fees to our collection agency.

I HAVE READ AND UNDERSTAND THE FINANCIAL ARRANGEMENTS REGARDING MY TREATMENT AT AMARILLO FAMILY CHIROPRACTIC.

SIGNED _____ DATE _____

NOTICE: If you have any questions or concerns, please feel free to ask any of our staff members for assistance.

THANK YOU!

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical modalities and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now, or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with the office personnel.

AMARILLO FAMILY CHIROPRACTIC

I understand the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks of treatment, including, but not limited to: fracture, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time based upon the facts then known, is in my best interest.

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(s) and for any future condition(s) for which I seek treatment.

All charges incurred at Amarillo Family Chiropractic are my total responsibility regardless of payment by my insurance policy or not.

If this account is placed with an attorney or collection agency for collection, I am aware of having additional attorney or collection agency fees added. If the attorney should have to pursue litigation, I also understand I will be responsible for additional court costs and/or attorney fees.

Print Patient Name: _____

Patient's Signature: _____

Patient's Representative's Signature: _____

Date Signed: _____

HIPAA Release of Information
AUTHORIZATION FORM

I, _____, hereby authorize Amarillo Family Chiropractic and its affiliates, its employees, and agents to release to _____ **[insert full name of person/organization]** my personal health information maintained by Amarillo Family Chiropractic (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me: _____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer by protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with _____.

I understand that I have a right to revoke this authorization by providing written notice to Amarillo Family Chiropractic. However, this authorization may not be revoked if Amarillo Family Chiropractic, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____

Date: _____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Name of Witness: _____

Signature of Witness: _____

AFC
AMARILLO FAMILY
CHIROPRACTIC
DR. DAMON CROSS

Medical Information Release Form

(HIPAA Release Form)

NAME: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by my in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell:

_____

If unable to reach me:

[ ] you may leave me a detailed message

[ ] please leave a message asking me to return your call

[ ] other:

_____

The best time to reach me is [day] _____ between [time]

_____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

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AMARILLO FAMILY
CHIROPRACTIC
DR. DAMON CROSS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, and the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- ✓ Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- ✓ Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- ✓ Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- ✓ The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- ✓ Most uses and disclosures of psychotherapy notes
- ✓ Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- ✓ Disclosures that constitute a sale of PHI under HIPAA
- ✓ Other uses and disclosures not described in this notice

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- ✓ The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited by it unless you agree in writing to remove it.
- ✓ The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- ✓ The right to inspect and copy your PHI.
- ✓ The right to amend your PHI.
- ✓ The right to receive an accounting of disclosures of your PHI.
- ✓ The right to obtain a paper copy of this notice from us upon request.
- ✓ The right to be advised of your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI. This notice is effective as of April 7, 2014, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulation currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and your may request a copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

AMARILLO FAMILY CHIROPRACTIC

DR. DAMON CROSS

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Dr. Damon A. Cross. I hereby acknowledge receipt of Amarillo Family Chiropractic's Notice of Privacy Practices.

Name [please print]: _____
Signature: _____
Date: _____

****

I am a patient or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Amarillo Family Chiropractic's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____
Relationship to Patient: ☐ Parent ☐ Legal guardian
Signature: _____
Date: _____