Scott Spine and Therapy Inc.
dba Summit Spine and Therapy
5750 E. 91st Street, Suite B
Indianapolis, Indiana 46250

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Summit Spine and Therapy *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

____ ______________________
Patient Name (print) Patient's Date of Birth

____ ______________________
Patient Signature Date

<u>If signed by a personal representative or legal guardian:</u>

Name of Personal Representative: _________________________________ ______________
(Print) Date

Signature of Personal Representative: ____

Relationship to Patient: ____________________ Driver's License Number: ____________State____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____________________________________Date __________ Staff: ____________

Attempt 2: _____________________________________Date __________ Staff: ____________

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PHI Use and Disclosure Authorization

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone, text or email

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Summit Spine and Therapy disclosure of my individually identifiable health information to the individuals listed:

1. Name ______________________________________ Relationship to Patient __________________

Authorization to:

- ☐ Disclose treatment plans and test results
- ☐ Billing information including statement balances
- ☐ Past and future Appointments
- ☐ Receive phone messages and/or email regarding appointments or test results
- ☐ Other ____

2. Name ______________________________________ Relationship to Patient __________________

Authorization to:

- ☐ Disclose treatment plans and test results
- ☐ Billing information including statement balances
- ☐ Past and Future Appointments
- ☐ Receive Phone Messages or email regarding appointments or test results
- ☐ Other ____

This authorization is effective through (check one):

- ☐ ____ /____ /____
- ☐ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Summit Spine and Therapy in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Summit Spine and Therapy until the termination request is received in writing and processed.

Authorization to Disclose:

____ ___________________________

Patient Name (print) Patient's Date of Birth

____ ___________________________

Patient Signature Date

____ ___________________________

Signature of *Personal Representative* if applicable **Date**

***Relationship* to Patient: ________________________Driver's License Number: ______________State____**

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INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment by the licensed Doctor of Chiropractic and/or therapist who may be employed by or engaged in practice in this clinic.

I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand as a patient of this clinic, I give the doctor and/or therapist permission and authority for treatment in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. It is the responsibility of the patient to make it known, or to learn through health care procedures whatever he or she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician/ Massage Therapist.

Our office has an open adjusting/therapy environment. Others may overhear conversations between you, your doctor and staff during normal treatments in the building. Our goal is to maintain as much privacy as possible. If you are uncomfortable discussing your case, you may request treatment in private room.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

I understand that if a chiropractic physician or therapist accepts me as a patient at Summit Spine & Therapy, I am authorizing them to proceed with the procedures prescribed for my condition and for any future conditions for which I seek treatment. Furthermore, I understand I have the opportunity to ask questions about my examination and treatment regarding my care at Summit Spine and Therapy.

Patient Signature: ____ Date: __________________

Consent for Examination and Treatment of a Minor Child

I ____, the Mother or Father or Legal Guardian of

(name of minor) ____ hereby consent to the performance of examination

and treatment by the licensed doctors of chiropractic and/or therapist who may be employed by or engaged in practice in this clinic to my child.

Signature: ____ Date: _____________________

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OFFICE & FINANCIAL POLICIES

PAYMENT OPTIONS: Cash, Credit Card, Direct Debit
STATEMENTS: If you have a balance on your account, we will send a statement in the mail. Not all accounts receive a monthly statement. Many patients pay at the time of service, in this case please request a statement when needed.
PAST DUE ACCOUNTS: Unless prior arrangements have been approved in writing by our office, the balance on your account is due and payable when the statement is issued and after 60 days, any outstanding balances will be due in full by you. Otherwise the amount will be automatically debited to your card on file.
INSURANCE: We verify coverage and provide an *estimate* of benefits. We ask that you also check with your insurance company about coverage in our office. If certain services are rendered and your insurance does not cover or pay, you will then become responsible for this amount. All co-payments, co-insurance and any patient responsibility is due at the time of service. Your complete insurance information must be presented at the time services are provided and our office must be notified of any changes in your insurance. You are considered a cash patient until you provide your insurance card or updated insurance card. If your carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. We do not accept assignments for out of network services or secondary insurance carriers however we are happy to provide you with a superbill to share with your insurance company.
SELF PAY: This includes any patient who does not have insurance or elects to not use their insurance or for services not covered by your insurance. Patients are required to make payment at each visit unless a payment plan is arranged. Please ask about CHUSA (ChiroHealthUSA) - a discount savings plan available to all patients in our office.
UNINSURED/SELF PAY & GOOD FAITH ESTIMATE (GFE): Under the law, we are required to offer you a GFE explaining how much your services will cost as a cash/self pay patient.. If you are self pay for any service initial here to receive a GFE: _____________
MEDICARE: Medicare only pays for spinal manipulations when the service is deemed to be medically necessary. If services are not deemed medically necessary an ABN form must be signed to show knowledge of the charges being billed and patient responsibility. Some, but not all secondary insurance companies will pay for non-covered exams or therapy charges. All non-covered services will be the responsibility of the patient.
APPOINTMENT(S): We have reserved appointment times especially for you therefore: we request at least a 1-day notice in order to reschedule/cancel appointments and to avoid a cancellation fee of $45. If you have a credit card on file this fee will be processed to the card on file.
RETURNED CHECKS: There is a $30 fee for any checks returned by a bank.
PAYMENT AGREEMENT: I have read and understand the above policies and my financial responsibility. Should I decide to discontinue treatment at any time, I will pay my balance in full at that time or arrange a payment plan in writing with the office. Should collection services be required, any fees for the services will be added to my balance and responsibility. Ledger balances may not exceed $200 at any time.
CREDIT CARD ON FILE: Credit cards are securely saved to patient accounts and will be processed for the balance due after services are rendered. This authorization will remain in effect until I cancel it in writing. I agree to notify the office of any changes to my account information. Please get my approval for any charge over the amount of $______________

______ I Authorize Summit Spine and Therapy to save my card for future use ______ I Decline/Do not Authorize

I have read and understand the above policies:

Patient Signature: ____ Date: _____________________

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ACUPUNCTURE CONSENT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I understand that methods of treatment may include, but are not limited to, acupuncture, ashi trigger point therapy, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment,but,as with all types healthcare interventions,there are some risks to care,including,but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of cupping. drBruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). By voluntarily signing below, I confirm that I have rea d, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

LICENSED ACUPUNCTURIST NAME: Dr. Clark Scott

PATIENT PRINTED NAME: ____

PATIENT SIGNATURE: ____ Date: ___________________

If patient declines, please sign here: _________________________________

Special Notice for Insurance Patients

Dr. Clark Scott and the team here at Summit Spine and Therapy are dedicated to providing you with the best healthcare possible, with the goal of you reaching your optimal health and function. For that reason, we will always recommend everything you need for the benefit of your condition and will not make recommendations based only on what your insurance will cover.

The decision to proceed with care is always up to you, the patient since your healthcare choices are a personal decision. With that in mind, this notice will help you understand what is covered by insurance in a chiropractic office, and what may be your responsibility.

This office offers many services that may either be considered non-covered or may be considered not medically necessary. In some instances, an insurance company may pay for a few services and then decide that further care is not medically necessary at that point. Any service deemed non-covered or not medically necessary will be the responsibility of the patient.

Some of these services may include, but are not limited to, those items listed below:

Evaluation and Management services (examinations) ($45-$300)
Adjustments to areas other than the spine, such as the shoulder, arm, hand, leg, ankle, and foot. ($30-60)
Physical therapy modalities and procedures, such as manual stretching and therapeutic cupping. ($10-$68)
Cervical or Lumbar Traction Device
Low Back Support Pillow
Nutritional Supplements
Custom Orthotics

Remember, it is the policy of this office never to turn any patient away from care due to financial circumstances. We offer many options to assist you with your financial responsibility and will explain each of these to you in detail.

We are happy to include you among our practice family. Please let us know about any questions you have related to your treatment here at Summit Spine and Therapy.

By signing this form you are stating that you understand that some or all of your services may be deemed non-covered or not medically necessary by your insurance carrier and you are agreeing to receive and accept financial responsibility for the services as recommended for your care.

____ ________________________

Patient’s Signature Date