Financial Agreement

The patient receiving our care pays our fees. We accept cash, checks or money orders only, no credit or debit cards. This helps avoid disputes or pressure to compromise your care from insurance companies and other third parties. *If requested,* we will supply (at no cost) you with a superbill containing the information your third party will need to process your claim. If you have health insurance, an HMO, PPO, depend on Medicare, were injured on the job, in an automobile accident or some other personal injury, please feel free to discuss your options with us.

First Visit On your first visit you will meet the doctor to discuss your current health situation and to see if you are a good candidate for chiropractic care. This consultation, which lasts about 15 minutes, is free. If we accept you as a patient, we will conduct a thorough examination and a deeper evaluation of your medical history. This history & examination helps us identify the likely cause(s) of your problem and helps us to formulate a treatment plan that is right for you. It takes about one hour to complete this exam. The cost is between $50 and $250 based on your age, the complexity of your medical history, and time spent.

We believe that you want to feel better as soon as possible so we prefer to adjust on your first visit. Some patients (those in accidents, who are of an advanced age or those having certain medical conditions) MAY require x-rays before we can safely adjust them. These patients will receive only soft tissue massage, acupressure, or similar treatments to comfort them until x-rays can be taken.

Many people seek chiropractic care to deal with occasional flare-ups of painful conditions and stop care after the acute stage has ended. Other patients prefer to work with the doctor on lifestyle changes even after their pain has passed. This preventative approach may require a longer treatment period initially, but clients choosing this route often find that they have improved overall health and are not as prone to future pain flare-ups. This is the care we recommend. Just as you brush your teeth daily or change the oil in your car, your body requires maintenance for peak performance. However, we are happy to treat all patients, whether they prefer responsive care or preventative care. We feel that how you manage your health is always your choice.

Regular visit At each appointment you will receive a chiropractic adjustment. In our office that means you will receive a combination of acupressure, energy medicine, deep tissue massage, myofascial release, reflexology, stretching, and a variety of chiropractic adjustment styles based on your individual needs.

We know that soft tissue work and retraining muscle memory is necessary to achieve lasting results. Chiropractors who bill insurance may offer these muscle-related services at an additional cost or eliminate them altogether. We include them in the cost of an adjustment for our TOS clients. A standard adjustment takes about 20 minutes and costs $40.00.

Financial Agreement Continued

Progress Examinations We will monitor your progress with periodic exams every 8-12 visits. If you have not received care for a similar problem in our office within the last 6 weeks but have had a new patient examination in our office within the last 12 months you will receive a re-exam. If you have a new problem or injury you may also be re-examined. These exams help both you and our office to document your health status and your recovery. We may modify your treatment plan based on your exam findings. The fee for the progress/re-exam is usually $25 for TOS patients.

Individual Consideration Contract If there is financial hardship associated with receiving care in our office please let us know so that we may tailor a payment schedule for you. Everyone deserves to feel good and we want to help make it affordable for you.

☐ CONTRACT ATTACHED

Billing Outstanding balances will be billed monthly and are considered past due 10 days after the invoice date. We will pass along the fee of $30 our bank charges us for any returned checks. Balances due beyond 30 days will be assessed a $25 fee per month, plus any legal and/or collection fees.

Our Promise We believe in the power of chiropractic to help you heal and we stand behind the quality of the care we offer. We cannot guarantee your results, but we want you to be satisfied that we will do everything we can to help you. If after two (2) visits, you become unhappy with your decision to consult our office we will refund the money you have paid us, minus $100 of the new patient exam fee, and make other care recommendations. Most of the time the healing process will take longer, but even during this early stage of care the majority of patients see enough progress to want to complete their care plan.

AGREEMENT **I accept full financial responsibility for my care.** I instruct this office to deliver care that, in their judgment, can best help me in the maintenance and restoration of my health. This is the entire financial agreement between T.A. Huffman, Inc. dba Huffman Chiropractic and the patient below. I have read this agreement, understand it, and agree with its provisions.

_____ Date:_____

Patient or responsible party

Our office does not participate in insurance of any kind. As required by law, we do not have a dual fee schedule. We maintain a published fee schedule for insurers who chose not to pay us the day services are rendered, and a deeply discounted one for those who pay TOS (at the time of service).

T.A. Huffman, Inc. dba Huffman Chiropractic
PATIENT CONSENT
FOR USE AND/OR DICLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree (print name)
as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning me at a phone number provided by me (home, cell or other) and leaving a message on my answering machine or with the individual answering the phone.

4. the Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. I am aware that Huffman Chiropractic is a HIPAA-free office.

_____ _____
Signature of individual printed above Date