Authorization and Release

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information 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 Patient Health Information 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 or do not want to receive your medical records, please inform our office.

In exchange for any credit provided to me by Palmer Chiropractic Clinic for services rendered, I agree to provide information and forms regarding any potential source of fee payment, to assist in any way I can and:

- If I am responsible for payment of my account without the help of insurance I agree to abide by whatever agreement I set up with this office to keep my account current.
- I hereby assign to this office my rights to receive payments from my insurance company or from any negligent party responsible for my injury. Payments should be mailed to:

Palmer Chiropractic Clinic, P.S.
10767 16th Ave SW.
Seattle, Wa 98146-2002

  If my policy prohibits assignment, then checks should be made payable to me and sent to the above address.
- I authorize the office to release any information to any insurance company, adjustor, or attorney that will assist in payment of a claim.
- I fully understand and agree that my insurance policy is an arrangement between myself and my insurance carrier. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.
- I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable at the discretion of this office. I understand that interest is charged on overdue accounts at the annual rate of 12%.
- In the event that legal action becomes necessary to collect any money due this office, I agree to the entry of a judgment in the amount equivalent to the unpaid balance plus interest at the rate of 12%, plus attorney and collection fees.

I have read and understand the policies of this office regarding my Patient Health Information and Financial Responsibilities:

Patient name: _____ Date: _____

Patient or Guardian signature: _____

A photocopy of this form shall be valid as the original.

PALMER CHIROPRACTIC CLINIC

Fee Schedule for Chiropractic Care

And Massage Therapy

New Patient Exams (depending upon level of exam) $45.00 - $130.00

Chiropractic Manipulation Therapy CMT (depending on # of Regions) $30.00 - $75.00

Diagnostic X-Rays (depending on # of Views) $39.00 - $249.00

Therapeutic Activities $30.00

Therapeutic Exercises $35.00

Mechanical Traction $30.00

Myofascial Release $30.00

1 Hour Massage Therapy $60

Insurance

We have direct agreements with many insurance providers. This allows us to bill those providers directly and collect a co-pay from you at the time of service. Please remember that your health insurance policy is an agreement between you and that company. You are still responsible for your account balance.

Healthy & Affordable Plan Packages

We offer affordable care plan packages that are tailored to your individual health care needs and financial situation. These plans can be prepared for you whether you have insurance coverage or not. If you would like an affordable Healthy & Affordable Plan Package prepared for you just ask us. We would be more than happy to help!

Important Notes:

Accounts with a patient balance over $100 will be charged a rebilling fee of 1% per month (accrued)

*Not all services are listed

PALMER CHIROPRACTIC CLINIC

MASSAGE POLICIES

To help you receive our best, all massage clients/patients are accepted for massage based on the following policies:

In order to insure that you receive the full hour massage, please arrive on time. The therapist must stop at the end of your scheduled time, due to the next appointment.

If you cannot keep your appointment, you must cancel within 24 hours or you will be charged a $35.00 cancellation fee.

Remember that healing takes time. Our clinic is set up to empower you with information to help you help yourself. With that in mind follow your licensed massage practitioner's recommendations. Ultimately you are responsible for your health.

I have read and understand the above policies and agree to abide by them.

_____. _____.

Date Client/Patient

Signature

_____.

Print name

Palmer Chiropractic
Privacy Notice Effective 1/1/2012

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Palmer Chiropractic Clinic respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment, payment, and health care operations.

Examples of uses and disclosures of protected health information for treatment, payment, and health care operations:

For treatment: Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others providing you care. This will help them stay informed about your care.

For payment: We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performs, or recommended care.

For health care operations:

We may use your medical records to assess quality and improve services.

We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.

We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.

We may use and disclose your information to conduct or arrange for services including: Medical quality review by your health plan; accounting, legal, risk management and insurance services; and audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of Palmer Chiropractic Clinic. The protected health information in it, however, generally belongs to you. You have a right to:

Receive, read, and ask questions about this Notice. Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.

Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").

Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.

Have us review a denial of access to your health information—except in certain circumstances.

Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.

When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.

Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing. Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to:

Keep your protected health information private.

Give you this Notice.

Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office/medical records department to pick one up.

To ask for help or complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact. **Palmer Chiropractic (206) 242-3700** If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also file a written complaint with the U.S. Secretary of Health and Human Services.

Notification of family and others

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

Some of the ways that we may use and disclose your protected health information without your authorization are as follows:

With medical researchers—if the research has been approved and has policies to protect your privacy.

To funeral directors/coroners consistent with applicable law to allow them to carry out their duties. To organ procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.

To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products. To comply with workers' compensation laws—if you make a workers' compensation claim.

For public health and safety purposes as allowed or required by law.

To report suspected abuse or neglect to public authorities.

To correctional institutions if you are in jail or prison, as necessary for your health and the health and safety of others. For law enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

For health and safety oversight activities for example, we may share health information with the Department of Health. For disaster relief purposes for example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

For work-related conditions that could affect employee health for example, an employer may ask us to assess health risks on a job site. To the military authorities of U.S. and foreign military personnel for example, the law may require us to provide information necessary to a military mission.

In the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order. For specialized government functions for example, we may share information for national security purpose.

Other uses and disclosures of protected health information: Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Dr. Diane Sherwood-Palmer may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ years of age.

I authorize the performance of diagnostic x-ray of this minor which Dr. Diane Sherwood-Palmer may consider necessary or advisable.

Signed _____ Date _____

Females:

Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Diane Sherwood-Palmer has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____