# Purcellville Chiropractic Center

	INSURANCE AUTHORIZATION O	<u>F TREATMENT, INSURANCE ASSIGNMENT AND RE</u>	<u>LEASE</u>
R. McW am fina	/illiams, D.C., P.C. all medical benefits, ncially responsible for all charges whet	with and ass if any, otherwise payable to me for services rendered her or not paid by insurance. I hereby authorize the efits. I authorize the use of this signature on all my insu FINANCIAL POLICY	I understand that I doctor to release all
<ol> <li>3.</li> <li>4.</li> <li>5.</li> </ol>	qualified and accepted my coverage, of I am responsible for any costs not consurance and one-time initial \$5 med Insurance Benefits quoted by my insurance. Dr. McWilliams makes every attempt to treatment received at one of our facilities provide this authorization in a timely mainsurance carrier has not paid a claim of McWilliams will submit an appeal one (responsible for taking an active part in balance and I authorize the use my credin full upon receipt of the bill.	ntil I have provided completed insurance forms, and t	ductibles, co pays, service. erage. enpanies for company does not to me. If my ssion, Dr. eppeal I will be ensible for the must remit payment
7. 8. 9.	and the courtesy of insurance assignmed agree to reimburse us the fees of any 25% of the debt, and all costs, and exefforts.  I agree that in order for Dr. McWilliams may contact me by telephone at any tele numbers, which could result in charges e-mails, using any e-mail address I has artificial voice message and/or use of ar agree that Dr. McWilliams may contact I understand that I can be charged a \$ advance.	ent is immediately discontinued. collection agency, which may be based on a percentage penses, including reasonable attorney's fees, we incut to service my account or to collect any amounts I may phone number associated with my account. This include to me. Dr. McWilliams may also contact me by sending we provided to them. Methods of contact may include a automatic dialing device, as applicable. I have read the me/us as described above.  25.00 NO SHOW fee for any appointment not resched	ge at a maximum of ir in such collection owe, Dr. McWilliams as wireless telephone text messages or using pre-recorded/is disclosure and duled or canceled in
mentio By Sigi	n of patient name) to analyze for rese	r in the treatment process may be used in its raw d arch purposes. I the Financial Policy, Insurance Assignment and In	•
Patient	's Printed Name	Signature of Patient (If patient is a minor, Parent or Guardian signs)	 Date
Rights a	E CHECK THE BOX, SIGN, AND DATE and Responsibilities:	CES AND PATIENT'S RIGHTS AND RESPONSIBILITY below to acknowledge receipt of the HIPAA Privacy Preserved Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice of Privacy Practices and Patient Rights and Responsible Notice Office Notice	actices and Patient

Signature of Patient

(If patient is a minor, Parent or Guardian signs)

Date

**Patient's Printed Name** 

#### CONSENT TO EXAMINATION AND CARE

I hereby authorize John R. McWilliams, D.C., P.C. and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include spinal manipulation and other tests and procedures considered therapeutically appropriate. I also wish to rely on the doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

they believe are in my best interest. The nature and purpose of the examination and evaluation, the treatment and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction. By signing below I acknowledge my consent to be examined: Patient's Printed Name Patient's Signature (parent/guardian for minor) Date The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan. Based on current findings, John R. McWilliams, D.C., P.C. doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment. To aid the understanding of my condition and the reasons for the proposed course of care, John R. McWilliams, D.C., P.C. doctors have answered my questions regarding the planned treatments and course of care that I will receive. John R. McWilliams, D.C., P.C. doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time. I have also been advised that although the incidence of complications associated with services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. I understand and accept that: I have the right to withdraw from or discontinue treatment at any time and that John R. McWilliams, D.C., P.C. doctors will advise me of any material risks in this regard. 2. That neither the physical therapy/chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care. 3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment. 4. John R. McWilliams, D.C., P.C. does not guarantee as to results with respect any course of care or treatment. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent. 5. I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by John R. McWilliams, D.C., P.C.. Signature of Doctor Patient's Printed Name Date Doctor's Notes: Signature (Parent/Guardian if patient is a minor) Date Patient counseled by: Discussion THE GENERAL ERISA ASSIGNMENT FORM The ERISA portion of the assignment will allow us to pursue any insurance entity, other than government entities such as Medicare and Medicaid, for payment of your denied claims in a more effective manner than is allowed under State law and will allow us to pursue these insurance companies for any ERISA claims procedures violations. I assign the right to payment for all medical benefits directly to John R. McWilliams, D.C., P.C. (Tax ID# 54-1918006) in consideration for medical services and supplies provided pursuant to my health insurance plan. In the event my health insurance plan refuses to pay for provided, medically necessary services, I also assign all my ERISA rights to John R. McWilliams, D.C., P.C. (Tax ID# 54-1918006) for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for faulty claims processing. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness John R. McWilliams, D.C., P.C. (Tax ID# 54-1918006) to see patients, including myself, on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services. I give consent to release medical information to John R. McWilliams, D.C., P.C. (Tax ID# 54-1918006). I give consent to John R. McWilliams, D.C., P.C.(Tax ID# 54-1918006) to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to John R. McWilliams, D.C., P.C. (Tax ID# 54-1918006) to send medical information, as necessary, to my insurance plan. \*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to \$110 a day for each infraction.

Signature (parent for minor)

Date

Print Name\_

# **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 review it carefully.

#### **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

#### Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

#### Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

#### Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

#### File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting Dr. McWilliams. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting

www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

#### **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care; Share information in a disaster relief situation; Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes; Sale of your information; Most sharing of psychotherapy notes

In the case of fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

#### Our Uses and Disclosures

We typically use or share your health information in the following ways.

**Treat you -** We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition

**Run our organization -** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.* 

**Bill for your services -** We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.* 

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: <a href="https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html">www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html</a>.

**Help with public health and safety issues -** We can share health information about you for certain situations such as: *Preventing disease; Helping with product recalls; Reporting adverse reactions to medication; Reporting suspected abuse, neglect, or domestic violence; and Preventing or reducing a serious threat to anyone's health or safety* 

**Do research** - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests** - We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests - We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions -** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

#### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

# Purcellville Chiropractic Center

### PATIENT RIGHTS AND RESPONSIBLITIES

## You the patient have the right to:

- Be treated with dignity and respect
- Confidentiality
- Participate in the assessment and care planning process
- Be provided service in a timely manner
- Be notified in advance of types of treatment and frequency of treatment being provided
- ❖ Be notified of any changes in your plan of care and treatment
- Receive an explanation of the billing process and an explanation of charges
- Express grievance without fear of reprisal or discrimination
- Refuse or discontinue

### You the patient are responsible for:

- Providing information when services are rendered
- Following the treatment plan as outlined by the doctor and scheduling for treatment at least 4 weeks in advance
- Notifying practice when you will not be available for treatment or will be late for treatment
- Rescheduling any missed treatment in order to keep on schedule as outlined in your treatment plan
- Performing all the rehab exercises including the prescribed home care program as outlined by the doctor
- Notifying the practice of any change in your condition, physician orders, attending physician, or attorney
- Notifying the practice of any incident involving the staff or equipment
- Payment of all co-payment or deductible applicable per the insurance plan of your choice

### PATIENT EMPOWERMENT CHECKLIST!

- 1. **COMMUNICATION** If your condition worsens, please contact Dr. McWilliams immediately. We are required to give you our cell phone number, our email or both.
- 2. FOLLOW UP Follow up with all of your doctor's self-care advice, such as:
  - > Performing all of your home exercise instructions. If you have any problems doing your home exercises, inform Dr. McWilliams immediately.
  - > Follow up with your icing instructions.
  - ➤ Watch your ergonomics. Take time to evaluate your work station and how you perform your home related activities and ensure you are always in the "good posture position."
- 3. UNDERSTANDING Ensure you understand all of your available treatment options, both inside and outside of John R. McWilliams, D.C., P.C., which your doctor has discussed with you.