RIVERSIDE CHIROPRACTIC LLC.
OFFICE POLICY

APPOINTMENT POLICY

Multiple appointments will be scheduled for your convenience, to minimize waiting, and to facilitate incorporating these appointments into your daily routine.

To achieve the best possible results in the shortest period of time it is necessary to maintain the schedule of care as outlined in your treatment plan.

Therefore, if you are unable to keep an appointment for any reason we require that you call immediately to reschedule your visit. It is your obligation to make up any missed appointments within 7 days of any cancellation.

This office reserves the right to charge for missed appointments and those cancelled without 24-hour notice.

When entering the office on any given visit, please do directly to the front desk and "sign in." We will do our best to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our policy please do not hesitate to speak to us directly.

FINANCIAL POLICY

1. As a service to our patients, this office will verify your insurance coverage, however this is not a guarantee of insurance coverage. Insurance coverage is a contract between you, the patient, and your insurance company.

2. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.

3. All payments are expected at the time of service or at the end of each week. Patients' balances may not exceed $250 at any time.

4. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service or at the end of each week. Insurance assignments patients' balances may not exceed $250 at any time.

5. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5 % per month. Charges may also be made for missed appointments and those cancelled without 24-hour notice.

Signature of patient or Responsible Party Date

Relationship to patient

Authorization to Release Information

Please Initial

_______I authorize this health care facility to release all information related to the care I receive, to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.

Information about Possible Risks of Treatment

Please Initial

_______Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headache and cervical spinal (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests will be performed to help identify if you may be susceptible to this type of injury, you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries, or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

Please Initial

_______I authorize the performance of diagnostic test, procedures and treatment deemed necessary by my Doctor of Chiropractic or other personnel involved in my care.

Please Initial

_______I authorize payment of medical benefits to Riverside Chiropractic, for services provided.

Guarantee of Payment

Please Initial

_______I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

____

Signature of Patient or Responsible Party   Date   Relationship to Patient

____

Reason Patient is Unable to Sign

_ _

Office Use

Any questions regarding the above authorizations?

Patient states that they are informed with regard to these authorizations.

___________________________________   _____________   _________________

Patient Signature   Date   CT Signature

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

   You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

   You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5) We are permitted to use or disclose your health information in response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.
6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.

7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public.
8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
10) We are permitted to use or disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Wisconsin's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

1. those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. those disclosures made to you.
3. those disclosures we are permitted to make without your consent or authorization as described above.
4. those disclosures made based on an authorization you signed.
5. those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. those disclosures for national security or intelligence purposes.
7. those disclosures made to correctional officers or law enforcement officers.
8. those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact:

Riverside Chiropractic

301 E Main St.

Waterford WI 53185

(262) 514-3600

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Personal Representative Printed	Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices. If you have any questions please contact Dr. Jenny R. Geiger, Privacy Officer for Riverside Chiropractic.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I understand that I can receive a copy of this form on request.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Personal Representative Printed	Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.