Reilly Chiropractic, 4751 W. Park Ave., Chippewa Falls, WI 54729

Phone (715)723-2892 Fax (715)723-3540
doc@chippewachiropractor.com

I,(Patient Name) ___________________________ , the undersigned patient, acknowledge that I understand and agree to the following responsibilities and policies:

- TERMINOLOGY for CHIROPRACTIC CARE
  - Terms utilized in the office
- NOTICE OF PRIVACY POLICY
  - HIPPA guidelines and rights to records
- AUTHORIZATION FOR CARE
  - Side effects, Risks, and Treatment Authorization
- FEES and BILLING POLICY
  - Services are rendered to the patient
- COLLECTION PRACTICES
  - Payment Expectations and No Bill Policy
- CARD PROCESSING FEES
  - 5% Fee applied to payments made with a CARD
- Delinquent Account and Collections
  - Fees applied if account becomes delinquent
- CANCELLATION AND NO SHOW POLICY
  - $20 fee applied to account without 12 hour notice of cancellation
- Security of Credit Information
  - Contact information for credit, debit, or HSA card processing

I have read these aforementioned policies and have had the opportunity to ask any questions I may have had about them. Any questions I may have had about these policies have been answered to my satisfaction.

I have freely chosen to comply with these policies and elect for services with Reilly Chiropractic.

Patient: _____________________________________
(Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself)

____
Printed name of patient or responsible party

____
Capacity of responsible party (e.g. parent, guardian, etc.)

Date: ____________

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TERMINOLOGY for CHIROPRACTIC CARE

Adjustment is the ***specific application of forces*** to facilitate the body's correction of mechanical dysfunction.

Mechanical Dysfunction is an immobility of one or more of the joints of the body. This ***may or may not cause pain***. Directly correlated with ***abnormal posture, muscle tension spasms, range of motion stiffness, joint tenderness, and organ dysfunction***. This also will result in alteration of nerve function and ***interference of the transmission of nerve*** impulses, lessening the body's innate ability to heal and achieve optimal health.

Maintenance/Supportive Care is defined as "services that seek to prevent disease, ***promote health*** and prolong and enhance the quality of life, or maintain or ***prevent deterioration of a chronic condition***. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective, the treatment is considered maintenance care."

NOTICE OF PRIVACY POLICY *Initial* ______

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records for a fee within 14 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Print)____

Patient or Guardian Signature____ Date________

Witness Signature____ Date________

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AUTHORIZATION FOR CARE *Initial _____*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

Dr. Broghan Reilly, Reilly Chiropractic LLC 4751 W. Park Ave. Lake Hallie, WI 54729

I have had an opportunity to discuss with the above named doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

FEES and BILLING POLICY *Initial _____*

I clearly understand and agree that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. All services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable.

I have had ample opportunity to ask questions about my liability associated with the fees for a chiropractic adjustment and other procedures. The doctor of chiropractic and/or other office or clinic personnel have answered my questions to my satisfaction. I have reviewed a copy of the most recent fee schedule of services that may not be covered by my insurance regardless of insurance verification, and I have understand the fees associated with care at this office. I understand that I have the right to refuse this care and that by signing this form I will be fully responsible for the total billed charge(s) related to non-covered services. I have the right to request at any time a new copy of the fee schedule and/or an explanation of my treatment plan and the services I am receiving.

Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Reilly Chiropractic, LLC will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Reilly Chiropractic, LLC will be credited to my account on receipt.

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COLLECTION PRACTICES *Initial _____*

Our office seeks to run a "no statement" clinic using common sense collection procedures.

All patients at Reilly Chiropractic are **required to have a credit card on file** within the office. This card is held within our third-party credit card processor. Reilly Chiropractic will collect for copays, deductible, and coinsurance on the **SAME DAY that services are Rendered** based on an insurance verification of coverage and our standard billing rates. We understand that this collection practice may leave the patient with a credit any credit will be reconciled once a remittance or EOB (explanation of benefits) has been received by our clinic. Reconciling a credit on your account will be performed by adjusting collections at your next visit. In the event that our collections at the time of service were underestimated and/or insurance coverage was denied, your credit card will be **automatically processed to cover any remaining balance** on your account.

- If you **wish not to provide credit card information** you will be expected to pay the full amount for services rendered PRIOR to receiving any such services.
- You are **not required to pay with the on-file card**. Payments made with the on-file card shall be subject to the card processing fees.

CARD PROCESSING FEES *Initial _____*

Any payment received via credit, debit, or HSA card shall be **subject to a 5%** fee applied to my account. Payments made by cash or check shall have no fees applied. We will happily provide detailed receipts at no cost for submitting payments to your HSA, employer, or insurance company for reimbursement.

Delinquent Account and Collections *Initial _____*

If my account becomes delinquent and must be sent to a collections agency, I will be responsible for a collection cost finance charge of **35%** that will be applied to my account. I also understand that for every month that my account holds a balance, I will be charged an additional **1.5%** cost applied as interest charges.

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CANCELLATION AND NO SHOW POLICY *Initial _____*

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than **12 hours notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations and reschedules made less than 12 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 12 hours notification may be subject to a $20.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment are considered a NO SHOW. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice, thus they may be denied any future appointments. The Cancellation and No Show fees are the **sole responsibility of the patient** and must be paid in full before the patient's next appointment. Any fees applied shall be withdrawn the day of the No Show via the No Bill Policy and Automatic billing procedures.

We understand that special, unavoidable circumstances may cause you to cancel within 12 hours. Fees in this instance may be waived but only with management approval.

Reilly Chiropractic believes that a good doctor/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to Dr. Reilly.

Security of Credit Information *Initial _____*

CREDIT CARD PROCESSING

- Our Merchant Services are provided by ***NCMIC Merchant Services*** 800-396-7157, ext. 5606 (https://www.ncmic.com/financial-products/credit-card-processing/) in coordination with ***TSYS WebPass 800-390-7924*** (http://merchantexperience.com/)

- NCMIC is active in helping its customers maintain PCI compliance through its PCI Assurance Program. Reilly Chiropractic adheres to the stringent auditing requirements of PCI DSS (Payment Card Industry Data Security Standards).

Secure

- *What fraud features does TSYS WebPASS provide?* TSYS WebPASS offers Address Verification System (AVS), Cardholder Identification (CID) and Card Verification Value (CVV2) verification services. It's important to remember that all cardholder data is stored at a secure host, not on the PC processing the transaction.

- Reilly Chiropractic – and it's clients – will be protected from fraud with real-time processing, data protections and verification code support. Credit card data is transmitted with the highest levels of encryption and security protocols, and compliance updates are seamlessly integrated into the application, with no action required by you.

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CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

As your chiropractor, I understand that individually identifiable information about you and your health is private, and I am committed to protecting the confidentiality of that information. I would like to communicate with you by e-mail about items and services that I think would supplement or enhance your treatment. Before instituting such e-mail communication, I wish to obtain your written authorization to ensure that you agree to my sending such e-mail communication. By signing this form, you will provide authorization for me to contact you by e-mail. Please read the information carefully before deciding whether to sign the form.

---- Dr.Broghan J. Reilly M.S., D.C.

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.
____(Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. **I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing**. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information email address and cell phone listed in my demographics. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wire-less plan (contact your carrier for pricing plans and details.

Signature		Name (please print)		Date	

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

By signing this form you will authorize Reilly Chiropractic to communicate with you by e-mail about items and services that we think would supplement or enhance your treatment. Your email address nor your personal information will not be shared with external companies.

In order to send the e-mail communication, we will use the e-mail address that you provide above. The e-mail message we send to you may also include your name and certain dates and other information related to your treatment. Once this information is disclosed to a third party, it may no longer be protected by federal privacy law.

This authorization will not expire, unless you revoke it in the office. Your refusal to sign this form or your decision to revoke your authorization will not affect your treatment except to the extent that we will not be able to communicate with you by e-mail. Your refusal to sign this form or your decision to revoke your authorization will not affect payment for your health care. If you do decide to revoke your authorization, that revocation will not affect any e-mail communication we had already sent to you in reliance on your authorization.

You also have a right to receive a copy of this form after you have signed it.