Harmon Chiropractic

Dr. Katharine Harmon
4127 Mexico Rd St. Peters, MO 63376

OFFICE BILLING POLICY

Self Pay:
A self paying patient does not have insurance or does not wish for the office to bill their insurance. Payment is expected in full at the time of service.

Major Medical/Group/individual insurance:
It must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amount not paid by your insurance company. The office will file your claims and assist you in any way we can. Please keep the following in mind:

a. Almost all insurance contains a deductible clause. The office must have verification that your deductible has been met. Most group insurance pays 70-80% on a claim. However, some groups choose to exclude chiropractic services or limits the number of visits per year.
b. Our office will bill your insurance company for the Chiropractic services you received in our office. Many insurance companies do not pay for supplements or supports. If the insurance company does not cover them, it is your responsibility.
c. If you discontinue care, the balance of your account is due and payable immediately even if you insurance has been filed. When your insurance pays, you will be refunded any amount due to you.
d. The office does not guarantee that your insurance will pay and/or even give the correct benefit information. The office will make every attempt at the beginning of care to receive verification of your coverage, however, if for some reason the claim or any part of it is denied, YOU ARE RESPONSIBLE for the full amount of your bill.
e. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

_____
Patient Signature and Date

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CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.
There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or maybe caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

I acknowledge I have discussed the following with my healthcare provider, the condition that the treatment is to address, the nature of the treatment, the risks and benefits of that treatment, and any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with
_____ (health care providers name).

Dated this _____ day of _____ 20___

_____
Patient signature (or Legal Guardian)

Print Name:_____

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DOCTOR'S LIEN, HEALTH REPORTS, AND PAYMENT RESPONSIBILITY

Patient Information:

Name: Social Security Number:
Address: DOB:
City/State/Zip:
Phone:

I hereby authorize and direct, you, my attorney, and/or insurance company, to **pay directly to Harmon Chiropractic, LLC** - Katharine Harmon, D.C. such sums as may be due and owing her for professional services rendered to me both by reason of this illness or accident and by reason of any other bills that are due to her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary tp adequately protect said doctor. ***I hereby further give a lien*** on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to my attorney, or myself as the result of the illness or injuries for which I have been treated or injuries in connections therewith.

I hereby authorize **Harmon Chiropractic, LLC-** Katharine Harmon, D.C. to furnish you, my attorney and/or insurance company, with a full report of her diagnosis, treatment, prognosis, etc., of myself in regard to the illness or injury in which I was involved.

I fully understand that I am directly and ***fully responsible*** to Harmon Chiropractic, LLC- Katharine Harmon, D.C. **for all medical bills submitted by her for services rendered to me** and that this agreement is made solely for his/her additional protection and in consideration of her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I amy eventually recover said fees. I also understand that any insurance filed on behalf of myself by **Harmon Chiropractic, LLC** is strictly a courtesy and I am responsible for monies owing this office. I further agree to pay all cost, attorney's fees and collection fees that **Harmon Chiropractic, LLC** may incur in attempting to recover payment of money I owe pursuant to this agreement, and to pay 9% interest on all sums outstanding more than 30 days.

Patient's signature:_____ Date_____

Print patient's name_____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow Harmon Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Harmon Chiropractic to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain the copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and summit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Harmon Chiropractic – Dr. Katharine Harmon has the right to refuse care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date