Tinkle Chiropractic, Inc.
212 N 8th St Rd.
Richmond, IN 47374

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

X_____ _____
Signature/Signature of Representative Date

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Financial Policy

Patients with Insurance

Co-pays, deductibles, and co-insurance are due at the time services are rendered. **You are responsible for your portion of the bill regardless of whether your insurance carrier pays their portion.** As a courtesy to our patients, we will file your insurance claim to your primary insurance carrier. We have nothing to do with how your insurance carrier will process the claim once they receive it. Any questions regarding your insurance will need to be directed to the insurance carrier/company.

Medicare Patients

Medicare and Medicare supplemental policies **do not** cover x-rays, exams, or therapies at any chiropractic office.

Tricare

Does not cover chiropractic care off a military base.

HIP

Some divisions of HIP (Healthy Indiana Plan) do not cover chiropractic care.

Cash Patients

We offer a time-of-service discount for patients that do not have health insurance or do not wish to use health insurance for their visits. Your first initial visit will be more than each visit after. If payment is not made at the time-of-service, you will be charged the full amount for services rendered.

Billing Policy

Any outstanding balances are subject to a $10 late fee per month if no payment is received. Account balances over $300 will have a fee of 5% of the total balance added per month when no payment has been made. Any account overdue for 3 months will be sent to collections. Once an account is sent to collections all inquiries must be directed to **Finance Systems**. Collection fees are 50% of your balance.

We reserve the right to dismiss you as a patient if you miss more than 3 appointments without prior notice. This will be at the discretion of the doctor.

It is your responsibility to notify us if your address changes so your bill is received on time.

It is also your responsibility to provide updated insurance information if there are changes, to ensure billing is submitted correctly on your behalf. If a change in insurance is not provided and claims denying the balance of the claim, will be the patient's financial responsibility.

By signing below that you agree to our financial policy.

X_____ _____

Signature Date