



Office Policies

- 1) Please be on time for your appointment. Being late or canceling at the last minute will cause scheduling disruptions which interfere with excellence in care for you and other patients who may be waiting.
- 2) Please do not wear strong perfume, colognes, etc., to this office, as Dr. Fox treats many people with allergies, and this will impair their progress.
- 3) Missed appointments may be charged for. In addition, continual cancellation may result in your dismissal as a patient.
- 4) Personal cleanliness is essential. Please schedule your appointments at a time that will allow you to comply with this. If necessary, carry a clean set of clothes in your car.
- 5) Children are very welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times.
- 6) We will work with you to schedule multiple appointments. This will help insure convenient appointment times for you.
- 7) If you need to spend extra time discussing your health care with Dr. Fox, please let our front desk know so we may schedule your appointment accordingly.
- 8) Dr. Fox must be notified of any changes in your health care, regardless of significance.

Financial Policies

- 1) We accept the following forms of payment: Cash, Checks, Visa, and Master Card.
- 2) Payment is expected at the time of the visit, including co-payments and deductible amounts.
- 3) We bill primary insurance companies for Initial Intensive Care as a courtesy to you.
- 4) The patient is always responsible for payment for his/her care. An insurance contract is between the patient and insurance company.
- 5) Insurance coverage is never guaranteed. If there are any problems between you and the insurance company, you may choose to assist us in billing by filing a dispute with the insurance company directly. Your signature below assigns assignment to Fox Chiropractic, Inc., for collection of payments.
- 6) Accounts 30 days past due will be charged a 1% service fee, compounded each month.
- 7) We may send an account balance to collections if we deem necessary. Any additional collection fees incurred are the responsibility of the patient.
- 8) We do offer a time of service discount when services are paid in full at the time of your visit. This discount will be passed on to your insurance company.
- 9) In some cases, we may have a contract in effect with your insurance company governing how we handle your account. This contract may prevent us from offering a time of service discount.
- 10) Please feel free to ask our office manager questions about your account.
- 11) Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way implies or guarantees that your care here will be covered by your insurance company, and you will be responsible for paying your account, regardless of coverage.

By signing below, I state that I understand the policies as explained herein.

Patient or guardian: _____ Date: _____

Witness: _____ Date: _____

Patient Name: _____



Patient Consent for Typical Uses and Disclosure of Protected Health Information

I hereby give my consent for Fox Chiropractic, Inc., to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

With this consent, Fox Chiropractic, Inc., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Fox Chiropractic, Inc., may mail to my home or any other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements.

With this consent, Fox Chiropractic, Inc., may e-mail to my home or any alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that Fox Chiropractic Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Fox Chiropractic, Inc., may decline to provide treatment to me.

We, Fox Chiropractic Inc., keep a record of the healthcare services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Fox at 206-522-6339.

Notice of Privacy Practices Acknowledgment

By signing this form, I am consenting to allow Fox Chiropractic, Inc., to use and disclose my protected health information (PHI) to carry out treatment, payment and health care operations (TPO).

Further, by my signature below I acknowledge receipt of this Notice of Privacy Practices and Patient Consent for Typical Uses and Disclosure of Protected Health Information.

_____ Patient or legally authorized individual, Signature	_____ Date	_____ Time
_____ Printed name, if signed on behalf of patient	_____ Relationship (ie., parent legal guardian, personal representative, etc.)	

This form will be retained in your medical records.