High Desert Chiropractic & Massage

Dr. Brandi Kuhn - Dr. Joshua Kuhn - Dr. Jeremy Holbrook
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Financial Policy for either *Private Insurance or No Insurance*

As an integral part of our goal to provide thorough, quality care to our patients, a simplified procedure for payment of professional services and insurance billing has been adapted.

1. Payments may be made by either cash, check, Visa or Mastercard.
2. Should the insurance company require any further information, my signature below is sufficient authorization for this office to release any required information.

Note: Payment in full is expected at the time of service. However, if you are either unable to pay in full at the time of service or if you have insurance that covers chiropractic care the following will be in effect.

1. You (the patient) are expected to meet your deductible and keep your account current by paying the estimated unpaid percentage of fees not covered by your insurance carrier each visit (i.e. if your insurance company pays 80% of the costs, then your payments are 20%of the cost of each treatment.
2. You are responsible for both checking that your insurance company is paying in a timely matter, and that any outstanding balance is paid to High Desert Chiropractic. **If your insurance company is not keeping current, it is your responsibility to contact them for payment.**
3. Some insurance companies will send payment directly to the patient even though our office has "taken assignment" ;**you are responsible for signing the check over to our office immediately upon receipt of any money to be paid on your account with us.**
4. Either a *service charge or a flat rate fee* will be added to the outstanding balance on all accounts that are 30 days past due. You are responsible for any and all collection costs that are incurred as a result of nonpayment of your account. A minimum collection fee of $35 will be added to all accounts past 90 days overdue.

All health insurance plans represent a contact between yourself and your insurance company. *These contracts are not between the physician and the insurance company.* It is therefore your responsibility to see that the insurance carrier makes prompt payments on your account and to handle any dispute or question that may arise. Once again, any cost of treatment that the insurance company does not reimburse is the responsibility of the patient.

Privacy Policy

I understand that High Desert Chiropractic will use and disclose health information about me.

I understand that my health information may include information both created and received by HDC, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that HDC may use and disclose my health information in order to: Make decisions about and plan for my care and treatment; refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment; determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I have the right to receive and review a written description of how HDC will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

I fully understand the High Desert Chiropractic and Massage Clinic Financial and Privacy Policies

_____ _____
Patient's Signature Date

_____ _____
Witness Date