

PATIENT POLICY

We believe that a clear definition of our patient policies will allow both, the patient and the doctor, to concentrate on the big issue-REGAINING AND MAINTAINING YOUR HEALTH.

Please do not hesitate to bring your children to your appointments. We are a child friendly facility and offer an arrangement of toys for your children to play with during your appointments.

Please bring your spouse or significant other with you to your second appointment; the Report of Findings. We find it best to make decisions about your health together with your spouse or significant other.

APPOINTMENT POLICY

Multiple appointments have been scheduled for your convenience to minimize waiting and to help incorporate these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that **it is the frequency of visits and not the particular day of the week that counts.**

If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within 7 days of any cancellation.

When entering the office on any given visit, please go directly to kiosk desk and sign in. We make an effort to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointment, please do not hesitate to speak to the front desk assistant directly.

FINANCIAL POLICY

- Our office will provide specific benefits during the second visit; Review of Findings, please provide the insurance id and insurance credentials on your first visit.
- A \$25 return check fee is applicable for any returned checks from the bank.

PATIENT'S SIGNATURE _____ Date _____

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 will 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.

- The patient understands and agrees to allow this chiropractic office 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 this chiropractic office 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.
- The patient has the right to examine and obtain a 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 submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- 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.
- Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. 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.
- Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
- Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
- This notice is effective on the date stated below.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

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

Name of Patient

Date

For further information regarding this notice, please speak with Doctor Schwartz at (757)962-6191



Premier Health Chiropractic

633 Independence Blvd. Suite A, Virginia Beach VA, 23462

Office # 757-962-6191

FAX # 757-962-7120

INFORMED CONSENT

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.

I have had an opportunity to discuss with the doctor of chiropractic named below 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.

Patient Signature _____

Date

Witness Signature _____

Date _____