Misra Chiropractic Clinic at The OM Center
Dr. Bibhu R. Misra, D.C., M.Sc., Dr. Hannibal Hervey, D.C.
21785 Filigree Court, Suite 200 Ashburn, VA 20147

HIPAA/ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received from **Misra Chiropractic Clinic (MCC)** a *Notice of Privacy Practices* for protected health information to review

Documentation of Good Faith Effort to Obtain Written Acknowledgment
I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that applies):

- ✓ Showing the patient, the Notice of Privacy Practices posted in our office.
- ❑ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ❑ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ❑ The patient refused to sign because he/she did not understand the form.
- ✓ Asking the patient to sign this Acknowledgment form.

_____ I give MCC permission to share my health information with my primary care physician (PCP NAME): _____

Office Location:_____ Phone:_____ Fax:_____

_____ I give MCC permission to share my health information with my referring physician (NAME)_____

Office Location:_____ Phone:_____ Fax:_____

_____ I give MCC permission to share my health information with the following: _____ Relationship: _____

_____ I give MCC permission to allow _____ to make changes to my appointments and for which I remain responsible

Patient Name _____ Signature_____Date _____

Witness Name (staff use only) _____Signature_____ Date _____

YOGA REHAB and MANUAL/MASSAGE THERAPY DETAILS and CANCELLATION POLICY (Insurance or self-pay)

Should the doctor prescribe manual therapies (i.e. medical massage/therapeutic activities/therapeutic exercises) as part of your care-plan to help you reach your health goals, this agreement is to help you understand what this entails and your responsibilities.

Therapy tailored for your needs:
Your therapist will be provided instructions by the doctor. Your session may include exercises, stretching; trigger point therapy, myofascial release, other manual techniques, and home education. Please be sure to communicate with the therapist if you are uncomfortable for any reason or if the pressure is too hard or too light, or anything else you deem helpful. If there are any new injuries, conditions or change in medications since your last visit, you must inform us of such changes ***before*** treatment begins. Sessions are scheduled in 30 and 60-minute segments. This includes time for the therapist to review your intake and ask any relevant questions, as well as time for you to undress and redress following the treatment. Because sessions are scheduled back to back, it's important you are on time for your session. If you are late, your session may be shortened or canceled.

Cancellation policy:
Please consider your therapist is paid by the work they are ***scheduled*** to perform. If you cannot make your appointment or need to reschedule, please do so 24 hours before your session. Failure to do so will result in a $50 cancellation/no show fee as MCC must still pay the therapist for their time. Emergencies are considered. (Note, last-minute work schedule or child care conflicts are not considered an emergency). I understand the above.

Patient Signature_____ Date _____ Witness Signature _____Date_____

PATIENT INFORMED CONSENT

I hereby request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical medicine 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 another office or clinic.

I have had an opportunity to discuss to my satisfaction 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 have also been advised of alternatives to chiropractic care and have had all questions and concerns pertaining to the alternatives addressed to my satisfaction.

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, strains 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 his/her clinical judgment during the course of care to determine what procedure(s) are necessary at the time (based upon the facts known to him/her) that is in my best interest to address my condition(s).

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_____

Insurance Assignment Policy and Agreement

We will do our best to accurately verify and file your insurance for services, however, benefits quoted by your insurance carrier are not a guarantee of payment. All current insurance information must be provided at the time of service, including any information relating to any open **worker's compensation** or **personal injury cases**. You are responsible for all copays, co-insurance, deductible and non-covered services on the day services are rendered.

If your insurance denies any service for any reason, you will be responsible for full payment to us. You may pursue any reimbursement you deem payable directly from your insurance company.

Unpaid Balance

You will receive monthly statements for any unpaid balances. Payment is due within 30 days of receipt. We will make every effort to work with you to resolve any outstanding balance should you be experiencing financial difficulty. **Failure to pay or address your balance within 30 days will result in collection and additional fees.**

Signature and Agreement

With my signature below, I confirm that I have been informed of and understand the above outlined policies. I authorize The OM Center to act as my agent submitting to my insurance claims, and I authorize payment of these benefits directly to The OM Center on my behalf for any services. I authorize any holder of my medical information to release information needed to determine benefits payable for rendered services. If I have additional insurance, my signature authorizes release of my medical information to any insurer agency I have given and authorizes my doctor to act as my legal agent. If my insurance does not cover any portion of this visit, I further acknowledge that I am responsible for payment of these services. Unless revoked by me in writing, this authorization is effective for my lifetime.

Date ----------

Relationship to patient ----------

Patient/ Legal Guardian signature ----------

Witness signature ----------

Out of Network Insurance Assignment Policy and Agreement

Your insurer uses a third party payer/administrator for its chiropractic care in some or all of its plans. Unfortunately, we are not in network with this third party. Accordingly, your benefits are available thru your "out of network" benefits.

You have a $_____ deductible on your out of network benefits. To date, your insurers website shows $_____ remains to be met. This figure may be lower if you have recently been treated by other medical providers.

This means you must pay this deductible amount before your insurance will cover your care. When you have met your deductible, you will be responsible for a ____ coinsurance. That is roughly $____ a visit.

We will submit your claims to your provider. Until your deductible is met, our office policy is to collect $60 per visit ***toward*** the fees. You will get a balance bill monthly for the remainder of charges once your insurer has processed your claims. Collecting $60 simply helps prevent you getting a large bill all at once.

If you have an unusually high deductible, which you don't believe you will meet, it may make more sense for you to avoid using your insurance and opt to be seen as a cash patient. Cash rates are legally discounted as we don't have administrative costs of filing with insurance. **All fees are due at the time of service** and you are given an approximate 15% time-of-service discount. The cash fee schedule is attached.

You are able to use your flex spending/medical savings account for cash services and should you choose to do that we will provide receipts with documentation.

I, _____, acknowledge I have read and understand the above-noted policy and that any questions I have were answered.

(CHOOSE ONE)

_____ I opt to submit to my insurance

_____ I opt to not submit to my insurance and to do the discounted cash rate.

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