The Art of Healing Chiropractic Clinic
16630 Imperial Valley Dr. Ste 115
Houston, Texas 77060
(713) 730-4527 Fax (713) 904-1633

Financial Policies

Our purpose is to provide the very best chiropractic care possible. One of the ways we accomplish this is to eliminate potential problems that may detract from the quality of our work. Therefore, we have developed the following financial policies:

We will verify your insurance coverage and review your benefits with you. Keep in mind that verification of benefits is not a guarantee that your insurance company will pay for all services rendered. You may request a copy of your verification page at any time.

We will bill your insurance company for your treatments. Any unpaid balance that your insurance company has not paid will become your responsibility.

All co-payments MUST be paid at the time services are rendered. Should any patient wish to make monthly payment arrangements, please see the office manager for additional information.

A current copy of the patients' insurance card is required in order to file claims. All services received prior to insurance verification must be paid in full at the time services are rendered. When the dates of service in question are paid in full by your insurance carrier, all over-payments will then be credited to the patients account.

Should your insurance carrier change during the course of treatments or between visits, it is patients' responsibility to update their insurance information with the billing department. The office will conduct yearly audits for benefits and demographics in September and January.

Initial _____

Con't Financial Polices

Non covered (through insurance) and cash paying patients agree to pay in full for services aligned with The Art of Healing fee schedule.

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Claims for Personal Injury

We will file personal injury claims to your auto insurance carrier via your PIP or Med Pay policy for your treatments. If your benefits are maxed before treatment ceases then we can file your health insurance for the remainder of your care. Any balance will be the patient's responsibility. It is not our policy to send claims to any auto insurance carrier other than our patient's insurance carrier. We will also accept patients with an LOP from their attorney.

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Consent to Treat Minor

I hereby authorize **Andrea Smith, D.C.,** and any staff member she may designate as assistants to administer chiropractic care as deemed necessary to my child for the course of my child's treatment. Initial _____

Claims for Workers Compensation

Patients should report the injury to the employer immediately after the incident, and you MUST have a claim number in order to file medical claims. Your employer may need to fill out information in order to submit claims to the insurance carrier. Workers compensation cases that are denied may then be submitted to health insurance carriers for payment, or be turned over to the patients cash balance. If you wish to appeal a denial a monthly payment arrangement will be necessary in order to avoid collection procedures.

Initial_____

HIPAA/Consent

I understand that **Andrea Smith, D.C.,** may use and disclose my protected health information for the purposes of treatment, payment and health care operation. I also acknowledge that I have read, or received a copy of the Notice of Privacy Practices, which provides information about how **The Art of Healing** and individuals involved in my care in the practice, may use and disclose my protected health information. As states in the Notice, I understand that I can contact the privacy officer at 713-730-4527 with any questions or concerns.

Andrea Smith, D.C., has my permission to share health and account information with the individuals listed below:

Name Relation

____
____
____
____

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of (PHI) made by alternative means, such as sending correspondence to the individuals office instead of the individual's home.

Please indicate how you would like to be contacted:

Home Phone:____________________

- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Work Phone:____________________

- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Cell Phone:__________________________

- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Written information:

- ☐ Mail to home address
- ☐ Mail to work address
- ☐ Fax to this number:_________________

Referrals

It is the patient's responsibility to obtain referrals when necessary from their primary care provider prior to treatment.

I agree to pay in full for all services rendered without the required referral.

Initial _______

Supports & Supplies

Andrea Smith, D.C. may recommend a support or supplies that aids in the recovery of injuries, or assists staff with the application of physiotherapy. I understand should I decide to purchase said supports and supplies, my insurance carrier ***may*** determine that the support/ supply prescribed for me is not medically necessary (non-allowable). Further, I agree to pay for this support/supply even if my insurance carrier decides it is not allowable (not covered under my benefits). I will be credited any payment towards the support/supply that my insurance company remits.

Initial______

Thank you for reading and understanding our office policies and consents. If you have any questions please let us know. By signing below you agree to all the rules and regulations set forth by The Art of Healing that apply to your account.

____
Signature of Patient Date

____
Signature of Responsible Party Date

The Art of Healing Chiropractic Clinic
16630 Imperial Valley Dr. Ste 115 Houston, Texas 77060
Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Andrea R. Smith, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. A letter of protection issued by an attorney's office will not negate this assignment.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct my carrier to make all checks payable to The Art of Healing Chiropractic Clinic, and send to PO Box 3805 Humble, Texas 77347 . I instruct my attorney to provide on request to the above named provider, a settlement breakdown in accordance with the Safekeeping Property Rule, Sec. 1.15.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to The Art of Healing Chiropractic Clinic, and to send any and all checks to PO Box 3805 Humble, Texas 77347.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from ay other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:
I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec. 132.001(a)]

_______________________________ Date:_______________________

_______________________________ Date:_______________________

Authorization and Consent to Care

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 off site facility listed below or any other office or off site facility.

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.

Although spinal manipulation/adjustment is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

- Soreness – I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
- Dizziness – Temporary symptoms like dizziness and nausea can occur but are relatively rare
- Fracture/joint injury – I further understand that in isolated cases underlying physical defects, pathologies such as weak bones from osteoporosis may render the patient susceptive to injury. When osteoporosis, degenerative disc disease or other abnormality is detected, the treating doctor will proceed with caution.
- Stroke – Although strokes will happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that symptoms arising from a stroke are reported to occur one in one million.
- Physical therapy burns – Some of therapies used generate heat and may rarely cause a blistering, this should be reported to the doctor.
- Bruising- Bruising may occur after soft tissue manipulation (manual therapy)

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.

Print Name ______________________________ Date __________

Patient Signature ______________________________ Date __________

Doctor Signature ______________________________ Date__________

MEDIA RELEASE FORM

I, ________________________, grant permission to The Art of Healing Chiropractic Clinic, hereinafter known as the “Media” to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

❏- Videos ❏- Email Blasts ❏- Recruiting Brochures ❏- Newsletters ❏- Magazines
❏- General Publications ❏- Website and/or Affiliates ❏- Other: __________________

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below that is applicable to your present situation:

_____ - I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _________________________________ Date: ________________________

Name (please print): _________________________________

Signature of parent or legal guardian: _________________________________
(if under 18 years of age)

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