

Devine Chiropractic & Rehab Center P.S.

1205 2nd Avenue - Seattle, WA 98101
(206) 623.2225



DowntownSeattleChiropractic.com
(206) 623-2225

Office Policies

A clear definition of our policy allows us to concentrate on the big issue--restoring and maintaining your health. We are always happy to answer any questions you have regarding our policy, your account, or your insurance coverage.

Insurance Information

Health and accident insurance policies are an agreement between the insurance carrier and you, their insured. We will gladly prepare any necessary reports and forms necessary to assist you in filing claims with your insurance company. Any amount authorized to be paid directly to Devine Chiropractic & Rehab Center, P.S. will be credited to your account upon receipt.

All services rendered to you are charged directly to you and you are personally responsible for payment. In order to facilitate the correct and rapid processing of your insurance claim, you can do the following: Call your insurance agent to determine exactly what coverage you have. Ask what deductible, if any, applies to your policy; and how much of your claim will your insurance company pay.

1. Obtain insurance forms from your agent or company, fill in the required personal information, and bring them to our office. Be sure to write down all information concerning any injury (auto, freight lifting, slipping, etc.).
2. Please ask one of our staff to double-check your insurance forms. This will avoid unnecessary errors and give you a chance to ask any questions that you may have regarding your claim.
3. If your policy has a deductible, we suggest you pay this amount on the onset of your care. We also recommend that you keep your account current on at least a monthly basis. Any reimbursement from your insurance company will be promptly credited to your account or sent to you if you have already paid your bill.
4. If you are an auto accident or on-the-job injury victim, we suggest you discuss your coverage with our insurance office. We may have suggestions that will help you in this regard.
5. You will be asked to authorize Devine Chiropractic & Rehab, P.S. to furnish information regarding your case directly to your insurance company and to assign all benefits as a result of the claim. This will expedite its handling.
6. Please be informed of your own insurance coverage, and if you have any questions feel free to ask. Our staff is experienced in insurance claim handling and will be glad to help in any way they can.

Patient Payment Schedule

Our patients' health needs are paramount. Patients are allowed to receive the care they need and reduce the balance on a monthly schedule rather than paying for visits as they are received. Monthly payments are required on all unpaid balances.

Insurance Policy

Most insurance policies now cover chiropractic care. We will be happy to file your primary insurance forms for you and do everything we can to assure you proper reimbursement.

Appointment Policy

Please notify our office if you are not able to keep your scheduled appointment. You will not be charged for missed chiropractic appointments. Should you need to cancel or reschedule a massage appointment, we require at least 24 hours notice. Missed massage appointments without 24 hours notice will be charged unless that time can be filled by another patient.

Referral Policy

If you move from our area, we will be glad to refer you to another chiropractor. We will forward your x-rays and records after you sign a release / transfer.

Discharge Policy

If you terminate your care at *Devine* Chiropractic & Rehab Center before your doctor feels your condition has stabilized, any fees for professional services will be immediately due and payable, unless prior arrangements have been made.

I understand these policies and will honor them.

Signature _____

Date ____ / ____ / _____

Sincerely,

Dr. James Devine and staff at Devine Chiropractic & Rehab Center, P.S

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Our New Patient Promise

Our promise is based on the simple truth that if we satisfy and delight our patients, they will get well faster and be more likely to tell others about their chiropractic experience. This avoids costly advertising and helps keep our fees reasonable.

Since chiropractic results vary, we can't guarantee results, but we can promise your satisfaction. So, within seven days of beginning care, if you are not completely happy with your decision to begin chiropractic care, we will gladly refund the money you have paid us. However, within this trial period, we expect you will know that consulting our office was a wise decision.

Since most spinal problems involve muscles and soft tissues that are slow to heal, continued chiropractic care is often required for maximum improvement.

Accepted by

Date

Consulting Doctor

Date

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Informed Consent

I understand that my doctor's recommendations are paramount for my optimum health and improvement of my condition. Failure to follow my doctor's recommendations may hinder or slow my recovery and increase the number of visits required to correct my problem.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by any licensed doctor of chiropractic who treats me at Devine Chiropractic & Rehab Center, P.S.

I have had an opportunity to discuss with my doctor at Devine Chiropractic & Rehab Center, P.S. and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures.

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 of the procedure which the doctor feels at the time, based upon the facts then known, 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.

To Be Completed by Patient

Patient's Name: _____

Signature: _____ Date Signed: ____ / ____ / ____

Witness to Patient's Signature: _____

If a Patient is a Minor, Physically, or Legally Incapacitated to be completed by Patient's Representative

Patient's Name: _____

Name of Representative: _____

Signature of Representative: _____ Date Signed: ____ / ____ / ____

Relationship to patient: _____

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Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The information privacy practices in this notice will be followed by:

- Any health care professional that treats you in our office.
- All departments and units including the Billing Department.
- All full, part time, or contractual employees, including students affiliating with any of our clinics.
- Any business associate or partner of Devine Chiropractic & Rehab Center, P.S. with whom we share health information.

Our pledge to you: We value you as a patient and appreciate the opportunity to serve you. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. By law, we are required to:

- Keep medical information about you private.
- Give you this notice or our legal duties and privacy practices.
- Follow the terms of the notice that is currently in effect.

Changes to this notice: We may change our policies at any time. Changes will apply to medical information we already hold and to the future information after the change occurs. Before we make significant change to our policies, we will alter our notice and post the new notice for public view in our office. You can receive a copy of the notice at any time. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose your personal medical information: We may use and disclose medical information about you for any purpose regarding your **treatment, to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare), and **for health care operations** (such as comparing practice patterns to improve treatment methods).

- We may use and disclose medical information about you **without** your prior authorization for several other reasons, subject to certain requirements: for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, worker's compensation purposes, and emergencies**. We also disclose medical information when **required by law** (such as in response to valid judicial or administrative orders).
- We also may contact you for appointments reminders, or to tell you about or recommend possible treatment options, alternatives, health related benefits, or durable medical goods that may be of interest to you.

- We may disclose medical information about you to a friend or family member who is involved with your medical care.

Other uses of medical information: We will ask for your written authorization before using or disclosing medical information about you in any other situation not covered by this notice. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing.

Your rights regarding personal medical information: In most cases you have **the right to look at or get a copy of medical information** that we use to make decisions about your care, after submitting a written request. We may charge a fee for the cost of copying, mailing, or related supplies. If we deny your request to review or obtain a copy of your medical record, you may submit a written request for a review of that decision.

- If you think that information in your record is incomplete or incorrect **you have the right to request that we correct the records** by submitting a written request. We would deny the request when the information was not created by us, not part of the information maintained by us, or if the record was accurate. You may appeal in writing, a decision not to amend your record.
- **You have the right to a listing of those instances where we have disclosed medical information about you**, other than for treatment, payment, or health care operations or where you specifically authorize the disclosure. You must submit a written request stating the time period desired for the accounting, which must be less than a six-month period starting after April 14, 2003. The first disclosure list in a 12-month period is free.
- You have a right to a paper copy of this notice.

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than you home, by notifying us in writing.

- **You may request in writing that we not use or disclose your medical information** for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency.

We are not legally required to accept your request, but will consider it and inform you of our decision.

All written requests or appeals should be submitted to Dr. Devine.

Complaints:

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact Dr. Devine at 1205 2nd Avenue, Suite 120, Seattle, WA 98101.

- Finally, you may send a written complaint to the U.S. Department of Human Services Office of Civil Rights. We will be happy to provide the address.
- Under no circumstances will you be retaliated against or penalized in any way.

Acknowledgement:

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Date Signed: ____ / ____ / ____

Accepted by (your name)

Your signature