NEW YORK CHIROPRACTIC ASSOCIATES OFFICE POLICIES

1020 Park Avenue New York, NY 10028 Tel: 212-249-6767 Fax: 212-861-4769

We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor and staff, to concentrate on the big issue …. *REGAINING AND MAINTAINING YOUR HEALTH*.

APPOINTMENT POLICY

1. Multiple appointments will be scheduled for your convenience to minimize wait time and to facilitate incorporating 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 that counts, not the days.
2. If you are unable to keep an appointment for any reason, we require that you call 5 hours in advance to cancel/reschedule your appointment. **This office reserves the right to charge for missed appointments and those cancelled without proper notice. There is a $90 late cancellation/ no show fee. One late cancellation/ no show fee may be waived once a year.**
3. When you arrive for your appointment, please sign in at the front desk. We will attempt 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 appointments, please do not hesitate to ask a staff member.

FINANCIAL POLICY

1. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are financially responsible for all payments. Our office will bill your insurance carrier on your behalf if you have insurance that this office accepts. If your claims are denied by your insurance carrier, you will be financially responsible for the visits. **Most insurance companies do not cover maintenance or supportive care. If your insurance deems your care to be maintenance/supportive care, you will be responsible for the office visit.**
2. All payments are expected at the time of service or at the end of each week. Patients' balances may not exceed $150 at any time.
3. All insurance assignment patients must pay their deductible in full on the day of treatment.
4. Only cash and credit cards are accepted on your first visit. You may pay by check on subsequent visits. Returned checks and balances over 30 days may be subject to additional collection fees.

HIPAA PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The *Health Insurance Portability & Accountability Act of 1996 (HIPAA)* is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

1. We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations.
   Treatment - providing treatment and coordinating care with other healthcare providers who are directly or indirectly involved in treating you.
   Payment - activities such as obtaining reimbursement for services, confirming coverage, conducting billing or collection activities.
   Health Care Operations - your health information may be disclosed during audits by your insurance carrier and during staff training.
2. We may contact you to provide you with appointment reminders.
3. We may use or disclose your private health information (PHI) without your authorization when required by local, state and federal law.
4. You can restrict how your PHI will be used or disclosed to carry out treatment or obtain payment from third party payers. This request must be in writing. We are, however, not required to agree to a requested restriction. If we do agree then we must abide by it unless you agree in writing to remove it.
5. You have a right to inspect and to a copy your PHI as provided by law. To inspect your PHI, you must submit a written request.
6. You have a right to review a list of disclosures of your PHI as provided by law. Your request must be in writing. The request must state a time period and it may not include dates before April 14, 2003.
7. You may file a complaint with our privacy officer or with the Secretary of Health and Human Services if you believe that our office has violated your privacy rights.
8. You have the right to obtain a copy of this notice from us upon request.

PATIENT'S SIGNATURE _____PRINT NAME _____DATE ____/____/____