ACKNOWLEDGEMENT OF NOTICE
OF HIPAA

You May Refuse to Sign This Acknowledgement*

I have been offered/ received a copy of this office's Notice of Privacy Practices.

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Please Print Name

____
Signature

____
Date

We attempted to obtain written acknowledgement of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify): ____

● ●

Financial/Office Policy

HEALTH INSURANCE

Please realize that your health insurance is your insurance, not ours. We will do everything possible to help you get reimbursed from your insurance carrier, but the ultimate obligation for payment rests with you, the patient, not with the insurance company. **Co-pay is expected at the time of service.** If your insurance deductible for the year has not been met at the time of service, payment is expected in full on that day of service.

OFFICE VISITS

For office visits, treatment, x-rays, or supplies, **please pay at the time of service**. We gladly accept cash, check, Mastercard and Visa.

MEDICARE

We will file directly with Medicare and/or your supplemental insurance for you, but you are responsible for the charges that Medicare or your supplement does not cover or pay. If your **Medicare deductible ($135)** for the year has not been met and your supplement does not cover it, payment is expected in full on that day of service.

MEDICAID

You must have a current Medicaid monthly eligibility card and bring it to each visit. **Cost-share portion is expected at the time of services**.

WORKMAN'S COMPENSATION / MVA

If you are here because of a work related injury / MVA, we must verify the coverage of your medical bills from your employer and / or your MVA carrier, we need exact information from you on the time, location and nature of your injury. Please bring this information with you and notify the receptionist that you are covered under worker's compensation or automobile insurance. **If for some reason the worker's compensation or MVA information is not verified, then you, the patient, are responsible for the charges**.

CASH

If you are a cash patient, **payment is expected at time of service**. We gladly accept cash, check, Mastercard and Visa.

UNPAID BILLS

If the account must be turned over to collection, all costs and fees associated with such collections are the responsibility of the patient. Once accounts are turned over for collection, payments are due to collection agency.

I have read the stated financial policy of Sturgis Chiropractic Clinic and agree to abide by these terms.

GUARANTOR/PATIENT SIGNATURE____DATE____________