High Desert Chiropractic & Massage

Dr. Brandi Kuhn
Dr. Joshua Kuhn
Dr. Jeremy Holbrook
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Office 541-540-2155

HDChiro@gmail.com
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HIPAA Policy

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with chiropractic services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services to or to ensure that all administrative matters related to your care are handled appropriately, This specifically includes the sharing of information with other healthcare providers, laboratories and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in the office and will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments via telephone, text message, email or by any means convenient and requested by you. We may send you other communications informing you of changes to office policy that you may find valuable.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI and agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies to insurance payers in normal performance of their duties.
5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. You have the right to read, review and copy your health information and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to assemble your copy.
9. You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete.
10. You have the right to request from us a description of how and where your health information was used by our office for any other reason than for the treatment, payment or healthcare operations. Please let us know the time period for which you are interested. We may need to charge you a reasonable fee for your request.
11. We may change, add or delete any of these provisions to better serve serve the needs of both the practice and the patient.
12. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
13. You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised.

Thank you very much for taking the time to review how we are carefully using your health information.

I,_____date_____do hereby consent and acknowledge my agreement to the privacy terms set forth in the this form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____date_____
Witness

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Financial Agreement

As an integral part of our goal to provide thorough, quality care to our patients, a simplified procedure for payment of professional services and insurance billing has been adopted:

1. Please remember that insurance billing is not a substitute for payment. You are expected to keep you account current by paying your co-pay, coinsurance or treatment charge applied to your deductible at the time your treatment is rendered. Payment can be made by either check, cash, Visa, MasterCard, American Express, HSA and FSA cards.
2. If we are billing insurance insurance for you you are responsible for checking that your insurance is paying in a timely manner and that any outstanding balance is paid to High Desert Chiropractic. If your insurance company is not keeping current, it is your responsibility to contact them for payment.
3. You are responsible for all balances your insurance company deems "patient responsibility".
4. Your signature below constitutes authorization for High Desert Chiropractic to to release any required information to your insurance company.
5. Some insurance companies will send payment directly to the patient even though our office has 'accepted assignment" you are responsible for signing the payment over to High Desert Chiropractic.
6. Either a service charge or flat rate fee will be added to the outstanding balance on all accounts that are 30 days past due. You are responsible for any and all collection costs that are incurred as a result of non-payment of your account. A minimum collection fee of $35 will be added to all accounts 90 days past due.
7. A missed appointment fee of $25 will be charged for any appointment cancelled under 24 hours from the scheduled appointment time.

I,_____date_____do hereby consent and acknowledge my agreement to the financial terms set forth in the this form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____date_____
Witness