Focused Care Patient Financial and HIPAA Agreement

FINANCIAL AGREEMENT:

I understand and agree to allow this chiropractic office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare, operations, and coordination of care.

I understand that a $500 non-refundable deposit is required to schedule my Focused Care treatment intensive. I understand that Morter HealthCenter requires three week's advanced notice of cancellation or rescheduling of my Focused Care treatment intensive. I understand that a one-time transfer of the $500 non-refundable deposit for a future Focused Care treatment intensive for myself is permitted outside of three weeks of my initial scheduled visit. I understand that if I need to cancel or reschedule my Focused Care treatment intensive and it is less than three weeks before my initial scheduled visit, then my $500 non-refundable deposit will become non-transferrable as well, and a new $500 non-refundable, non-transferrable deposit will be required to schedule any future Focused Care treatment intensives.

I understand that I am responsible for all costs of my Focused Care treatment intensive. I understand that this chiropractic office will not bill to any insurance for Focused Care treatment intensives.

I understand that the remaining $2350 balance for the Focused Care treatment intensive will be due at the time of service. I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for all scheduled, professional services will be immediately due and payable. I understand that I will be financially responsible for all collection/ legal fees incurred for the collection of any unpaid balance.

Patient Signature _____ **Date** _____

If the patient is a minor or under a guardianship order as defined by State Law:

By _____

Signature of Parent/Guardian (circle one)

Scott A. Cooper Inc. dba Morter HealthCenter
10439 Commerce Dr. Suite 140
Carmel, Indiana 46032
PH: 317-872-9300

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Scott A. Cooper Inc. dba Morter HealthCenter or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date