HEALTH PRIVACY NOTICE

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS OF THE WELLNESS CENTRE

I, (CLIENT'S PRINTED NAME) ___________________________________, **give consent to the provider office of Dr. Scott Balin, DC PA dba The Wellness Centre** located at 1432 FM 1463 Rd, Katy, Texas for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for products and services rendered to me, and for general administrative operations. I understand that as part of my health care, The Wellness Centre originates and maintains paper and electronic records describing my health history, symptoms, examinations and test results, treatment, and any plans for future care or treatment. I understand that this information serves as a:

- Basis for planning my care and treatment
- Means of communication among the many health professionals who contribute to my care
- Source of information for applying my treatment to my bill
- Means by which a third-party payer can verify that services billed were actually provided
- Tool for routine healthcare operations such as assessing quality

I understand and have been provided with the Notice of Privacy Practices (Dated January 1, 2008) that provides a more complete description of how medical information about me may be used and disclosed. I understand that I have the following rights and privileges:

- I HAVE THE RIGHT to review the notice prior to signing this Consent
- I HAVE THE RIGHT to object to the use of my health information for specific purposes
- I HAVE THE RIGHT to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I wish to have the following restrictions to the use of disclosure of my health information:

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I understand that I may revoke this agreement in writing, except to the extent that the organization has already taken actions thereon. I also understand that by refusing to sign this consent, this organization may refuse treatment as permitted by Section 164.506 of the Code of Federal Regulation.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my PHI to my insurance carrier or another entity, and I consent to such disclosure for these permitted uses, including disclosure electronically via facsimile, computer, or other device.

- All of the information I provided to The Wellness Centre is accurate and complete to the best of my knowledge.
- I understand that massage practitioners, estheticians, and other staff members do not diagnose or treat disease, nor give medical advice, and that any care or recommendation I receive is no substitute for a physician's care.
- I take responsibility for alerting my practitioners of any changes to my health status, medications, and therapies before the session, as well as any and all responses perceived to be a result of massage therapy or any other spa service as soon as I become aware of them.
- I understand that no sexual activity, comment, or innuendo will be tolerated. And I further understand that staff reserves the right to refuse services at its discretion based on the client's conditions, practitioner's skill set, client attitude or action, etc., without explanation or prior notice, and I agree to this policy and accept the terms of this consent.

Dated this _______ day of ______________________, 20 ___.

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Patient/Client Signature Date of Birth Social Security Number

*REASON FOR CLIENT'S REFUSAL TO SIGN:*____

*PRACTITIONER'S SIGNATURE*____ *DATE:* ______________________

HEALTH PRIVACY NOTICE

Please complete if you are or will be a patient of Dr. Scott Balin, Chiropractor

Patient authorization for the release of PROTECTED HEALTH INFORMATION (PHI) to provider/billing agent (HIPAA compliant)

I, ____, (patient/policyholder) hereby authorize

________________________________ (insurance carrier, legal representative) its agents, employees and associates to release the protected health information that is described below, to the provider office of Dr. Scott A. Balin, DC dba The Wellness Centre located at 1432 FM 1463 Rd, Katy, Texas or to the billing and collection agent/representative of same.

My insurance carrier, or legal representation (should this case involve a legal matter) is directed to make available all of my insurance information including coverage information, and all billing records showing all charges, expenses, costs and payments. Failure to provide such requested information, of which I hereby authorized the release of, by my signature, might have adverse affects on my physical, mental and emotional well being. I will hold any entity liable for such non-compliance with my authorization.

At my request, this information will be used for the purpose of establishing coverage, or payment, or billing, or establishing my legal claim.

This authorization may be revoked at any time by giving written notice to the healthcare provider and/or billing agent.

I understand that once PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, and insurance companies and may even become public record if filed with a court of law.

A copy of this signed authorization will be recorded in my medical record and available to me upon request.

Dated this _______ day of ______________________, 20 ___.

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Patient Signature Date of Birth Social Security Number

FINANCIAL POLICY

The Wellness Centre is dedicated to providing you the most efficient care and service possible. **Your understanding of our financial policy is an essential element of your care and service.** If you have questions regarding any aspect of our policy, please feel free to ask a staff member.

Full payment is due at the time of service. The Wellness Centre accepts cash, personal checks (in-state only), VISA, MasterCard, American Express and Discover. There is a service charge for returned checks.

If you are using insurance, and have signed an "Assignment of Benefits" statement, we will bill your insurance carrier for you if we are a provider on your plan as a courtesy to you. Balances are due within thirty (30) days of the billing statement date. This will only be excepted if you have made arrangements with the billing department prior to your visit. **Any balance unpaid after ninety days may be turned over to a collection agency.**

We will gladly contact your insurance carrier and verify coverage & eligibility. **Please note that any benefit information furnished is neither a guarantee of payment nor a determination of medical necessity and final claim(s) determination will be made upon receipt and review of the insurance claim(s) by your insurance carrier.**

Our goal is to keep you informed and educated about your insurance coverage and financial responsibility. Ultimately, it is your responsibility to know the details of your particular insurance policy. **Not all services are covered by all carriers.** Services which are not covered by your insurance are your responsibility. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance. If your insurance has a **co-payment** policy, the co-payment is due at the time of service. If you have a **deductible**, you are responsible for all charges until the deductible is met. You are responsible for any and all allowable charges which remain after your insurance has paid its portion.

If your insurance carrier has a **"network"** of providers, it is your responsibility to make sure that we are an "in network" provider prior to obtaining services. If we are not "in network," we will still be happy to provide services; however, the percentage of charges for which you are responsible will be greater. It is also your responsibility to make us aware of any restrictions your policy has on ancillary services.

It is your responsibility to make sure we have accurate insurance carrier information and billing information. If a claim is unsuccessful because of flawed insurance or billing information, you will be responsible for the balance.

We will make every effort to assist you in understanding the above information. We will also assist with any problems arising with your insurance to the extent we can accommodate.

CANCELLATIONS AND NO-SHOWS

We will make every effort to accommodate appointments that fit your schedule and medical needs. Please honor our 24-hour advance notice cancellation policy. **Late cancellations or no-shows may be subject to a fee equal to 50% of the service initially scheduled.** If you will be utilizing your health benefits, please be aware that your insurance carrier will not pay for missed appointments.

I have read and understand the Financial Policies of The Wellness Centre. I agree to assign insurance benefits to The Wellness Centre whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections. I acknowledge that I will be responsible for any fees incurred regarding the cancellation policy.

Patient/Client:

Signature Print Name Date

Date of Birth

CONSENT FOR TREATMENT

Our intention is to facilitate you through a healing process which includes physical, emotional, and mental levels. We believe that a balanced state on all of these levels leads to your health and well-being.

Our staff consists of licensed Doctors, Acupuncturist and Therapists and full specialist technicians with a broad scope of certifications. Staff members are available to be your facilitators but you are always in charge of yourself and your session.

Communication is the key to getting the treatment you want. We ask that you give verbal feedback to your practitioner throughout your session. If you are uncomfortable let your practitioner know immediately. If you have questions about your treatment please ask your practitioner for clarification. Your health needs and comforts will always be honored.

At times your practitioner may ask about major stresses in your life, belief systems, health history, childhood, and other issues that influence your well-being. These discussions will be kept confidential. Please be aware that our staff may be discussing your work in confidence with a supervisor in order to develop the best healing plan for you.

We are not medical physicians and therefore do not diagnose or prescribe medications. Our staff will never advise you to discontinue any medical treatment you may be receiving. Our work is intended to be harmonious with other health practices, including allopathic medicine. Please feel free to discuss your treatments here at The Wellness Centre with your doctor or therapist.

Hydration is essential after all treatments. The release of tension from your muscle tissue releases toxins that must be eliminated from your body. Make sure to drink plenty of water after a treatment and throughout your day to help flush out these toxins so that they are not reabsorbed by your system. Soaking in a warm tub with Epsom salts the evening of your treatment is also a wonderful remedy. Most importantly, listen to your body as it communicates what it needs and honor yourself by meeting those needs.

If you have any questions at this time please ask us for assistance. In signing the attached Acknowledgment and Release, you state full understanding of the information stated above.

ACKNOWLEDGEMENT & RELEASE

I hereby acknowledge that I have read the foregoing Consent for Treatment, am satisfied that I fully understand the nature of the treatments, and freely elect to receive these treatments. I release Scott A. Balin, DC PA dba The Wellness Centre from any and all claims of malpractice, non-disclosure, or lack of informed consent. I freely assume any and all risks of the treatment whether presently contemplated or hereinafter discovered.

Print ____ Birth Date _______________________

Sign ____ Date____________________________

INSURANCE COLLECTION POLICY

Please note that any benefit information furnished by your insurance carrier is neither a guarantee of payment nor a determination of medical necessity and final claim(s) determination will be made upon receipt and review of the insurance claim(s) by your insurance carrier. You are responsible for any and all allowable charges which remain after your insurance has paid its portion.

If your insurance has a **co-payment** policy, the co-payment is due at the time of service.

If you have a **deductible**, you are responsible for all charges until the deductible is met. We will collect an amount that is an approximation of the allowable charges as explained below:

Initial Visit	$145.00
Stem + Ultrasound Therapy & Adjustment	$ 65.00
30 Min Deep Tissue Session & Adjustment	$ 90.00
Spinal Adjustment Only	$ 45.00

If your insurance has a **co-insurance** policy, the co-insurance is due at the time of service. We will collect an amount that is an approximation of the allowable charges.

**If you have Medicare or a Medicare Supplement Plan, the only covered therapy is a Spinal Adjustment. Should you decide to receive other therapies, you will be responsible for 100% of the charges.

Please note that once the EXPLANATION OF BENEFITS is received from your insurance carrier, you will be credited for any over-payment or billed for any allowable charges that remain after your insurance has paid.

I acknowledge and understand my insurance benefits and the billing practices of The Wellness Centre.

Signature of Insured
(or authorized representative)

Print Name