LOGAN VALLEY CHIROPRACTIC

JOSEPH R. BUMBARGER, DC

1710 6th Avenue
Altoona, PA 16602
(814) 944-8483

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the term of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of the patient):

PRIVACYASSIGNBENEFITS.FINANCIALPOLICY

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Assignment of Benefits Form

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Joseph R. Bumbarger, DC, d/b/a Logan Valley Chiropractic ("LVC") for any products or services provided to me by LVC.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to LVC, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by LVC.

I understand that I am financially responsible to LVC for any charges not covered by health care benefits. It is my responsibility to notify LVC of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined LVC and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products or services received.

By signing this document, I also acknowledge that I have received a copy of LVC's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

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FINANCIAL POLICY

Thank you for choosing Logan Valley Chiropractic (LVC) as your health care provider. We are committed to maximizing the success of your treatment. Following is our financial policy, which we require all patients to read and sign prior to being treated.

We accept cash, checks, Visa, and MasterCard. **All payment is due at the time of treatment.**

INSURANCE

Payment will be due by you at the time of service for any non-covered services, deductibles, or co-pays. If you have a deductible that has not been met, we will collect the full amount of fees for services provided on each visit, up to your deductible amount. Any fees collected exceeding the amount you are responsible for will be applied to future visits, credited to your account, or refunded upon request when there are not outstanding balances on your account.

Your insurance policy is a contract between you and your insurance company. Logan Valley Chiropractic has no authority over your benefits or coverage. While we do our best to work with your insurance company, the benefits quoted to us by your insurance company are not a guarantee of payment, and you are ultimately responsible for all fees for services provided. If your insurance denied payment for services your have received, you will be required to pay for those services in full.

CASH

If your insurance cannot be verified at the time of service, or you do not have insurance, then all fees must be paid in full, with applicable time-of-service discount. If you pay for all services rendered on the day that they are performed (time-of-service), then you are entitled to a reduction in fees. If you pay at a later date, the reduced rate does not apply. Discounted cap-fee plans and pre-payment plans are available for those experiencing financial hardship. We can also refer you to Preferred Chiropractic Doctor or Chiropractic Plans of America, companies which specialize in providing health-care payment plans.

You are responsible for paying your entire account balance, according to the terms listed above, regardless of perceived value, effectiveness of therapy, or expected outcomes.

When you receive a statement for payment due, please submit payment within 30 days of statement date. If no payment is received after three notices, your account may be turned over to our collection agency, and unpaid balances can be reported to the credit bureau which would be reflected on your credit report as a delinquent account.

The contact information you have provided on your intake form will be used to notify you. The address you provide is where Logan Valley Chiropractic will send all correspondence. The phone numbers provided will be where Logan Valley Chiropractic will call to notify you. If this information changes you must notify us immediately to prevent any miscommunications.

I have read and understand all of the information contained in this payment policy. All of my questions have been answered to my satisfaction. To the best of my knowledge, the information I have provided is true and accurate. I understand that I am ultimately responsible for paying for any services that I receive from Logan Valley Chiropractic and its employees.

Signature: _____ Date: _____

Witness: _____ Date: _____