

Barley Family Health Care & Rehabilitation

FINANCIAL POLICY

IT IS OUR OFFICE POLICY THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO YOU, THE PATIENT. YOU ARE ULTIMATELY RESPONSIBLE FOR ALL PAYMENTS REGARDLESS OF WHETHER OR NOT THIS OFFICE ACCEPTS INSURANCE ASSIGNMENT.

INITIAL:

- _____ THE PRIVILEGE OF INSURANCE ASSIGNMENT BEGINS WHEN ALL YOUR PAPERWORK IS COMPLETE AND SIGNED BY YOU, AND ALL DEDUCTIBLES HAVE BEEN MET.
- _____ OUR OFFICE WILL QUALIFY YOUR INSURANCE COVERAGE FOR YOU, BUT BENEFITS QUOTED TO US. DOES NOT GUARANTEE THAT YOUR INSURANCE CO. WILL PAY.
- _____ DEDUCTIBLES, COPAYMENTS AND OR COINSURANCE ARE EXPECTED AT THE TIME OF SERVICE. YOUR BALANCE MAY NOT EXCEED \$150.00 OR CARE MAY BE TERMINATED.
- _____ *CASH PATIENTS:* PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE. PATIENT BALANCES MAY NOT EXCEED \$150.00.
- _____ SOME INSURANCE COMPANIES DO NOT COVER MAINTENANCE CARE WE WILL VERIFY THAT WITH YOUR INSURANCE COMPANY, AND IF THEY DO NOT YOU WILL BE CONSIDERED A CASH PATIENT AT THAT TIME.
- _____ SHOULD YOU DISCONTINUE CARE FOR ANY REASON OTHER THAN DISCHARGED BY THE DOCTOR OR PHYSICAL THERAPIST, ANY AND ALL BALANCES WILL BECOME IMMEDIATELY DUE AND PAYABLE IN FULL BY YOU, REGARDLESS OF ANY CLAIMS SUBMITTED.
- _____ THIS OFFICE CHARGES A \$25.00 MISSED APPOINTMENT FEE FOR ANY APPOINTMENTS MISSED OR CANCELLED LESS THAN 24 HOURS IN ADVANCE.

IT IS THE GOAL OF THIS OFFICE TO PROVIDE YOU WITH THE FINEST QUALITY CHIROPRACTIC AND PHYSICAL THERAPY CARE AVAILABLE. IF YOU HAVE ANY QUESTIONS IN REGARD TO YOUR HEALTH CARE, OR ANY OF OUR OFFICE POLICIES, PLEASE LET US KNOW. WE WELCOME YOUR REFERRALS AND LOOK FORWARD TO A DOCTOR/PHYSICAL THERAPIST-PATIENT RELATIONSHIP THAT WORKS FOR MUTUAL BENEFIT.

SIGNATURE: _____ DATE: _____

PREGNANCY DISCLAIMER

THIS CERTIFIES THAT CONCERNS REGARDING PREGNANCY AND RADIATION EXPOSURE HAVE BEEN EXPLAINED TO MY SATISFACTION. I UNDERSTAND THE CLINICAL NECESSITY OF HAVING X-RAYS TAKEN AT THIS TIME AND GRANT PERMISSION FOR THIS PROCEDURE. IN SO DOING, I RELEASE THE DOCTOR/CLINIC FROM RESPONSIBILITY FOR POTENTIAL DAMAGE ARISING FROM THIS PROCEDURE.

AT PRESENT TIME: _____ I AM SURE THAT I AM NOT PREGNANT, _____ IT IS POSSIBLE THAT I AM
_____ I AM PREGANT. _____ PREGNANT

SIGNATURE OF PATIENT: _____ DATE: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

WE ARE VERY CONCERNED WITH PROTECTING YOUR PRIVACY, ESPECIALLY IN MATTERS THAT CONCERN YOUR PERSONAL HEALTH INFORMATION. IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996(HIPAA), WE ARE REQUIRED TO SUPPLY YOU WITH A COPY OF OUR PRIVACY POLICIES AND PROCEDURES. WE ENCOURAGE YOU TO READ THIS DOCUMENT CAREFULLY. IF YOU EVER HAVE ANY QUESTIONS OR CONCERNS REGARDING THE USE OR DISSEMINATION OF YOUR PERSONAL HEALTH INFORMATION, WE WOULD BE HAPPY TO ADDRESS THEM.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF BARLEY FAMILY HEALTH CARE AND REHAB'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

SIGNATURE OF PATIENT: _____ DATE: _____

**DR. DENNIS A. BARLEY
DR. TERRY J. SOUCIE**

**DR. JOSEPH P. SHERIDAN
ELAINE YOUMAN, P.T.**