FINANCIAL POLICY

It is the policy of this clinic to inform you of charges incurred so that you can plan for payment on an informed basis.

We accept **Automobile, Worker's Compensation and Major Medical insurance** coverage. We submit medical insurance forms as a courtesy to our patient and ask that deductibles and co-insurance payments be made at the time of service. Patients are responsible for any portion their insurance does not cover. Automobile coverage may be subject to a co-payment if 3rd party billing is required.
If Auto case, please ☐ check box and read and sign Personal Injury Financial agreement.

We submit **Medicare** claims, however, we do not accept assignment from Medicare. This means that Medicare will make any reimbursements directly to the patient. We, therefore, ask that Medicare patients pay for services at the time they are incurred.

Cash patients are asked to pay for services on each visit. Patients are required to make arrangements with the front desk in cases of hardship.

For all appointments: *Please arrive at least 10 minutes prior to your scheduled time*. If you need to cancel your appointment, please call the office at least 24 hours in advance, so we may reschedule. If you do not call, you will be charged for the appointment. It will not be billed to insurance.

Our charges are based on the usual and customary guideline for the area. Our standard charges are:

Office visit	$55.00 – 90.00
Office visits (children/students)	$25.00 – 40.00
Massage	$25.00 – 120.00
Brief Exam	$85.00
Detailed Exam	$150.00
Interim Exam	$110.00
Therapies (each)	$20.00 – 45.00

Information on charges for special services is available from the business office.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I hereby authorize Nova Chiropractic, Dr. Heather Shaw to furnish information to insurance carriers concerning my illness and treatments and hereby assign Nova Chiropractic, Dr. Heather Shaw, D.C. all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any and all amounts not covered by insurance in a timely manner. I also give this office power of attorney to endorse checks made out to me to be credited to my account. However, I clearly understand and agree that all services rendered me are charged to me. Balances overdue by 60 days may be subject to an 18% APR finance charge or $5.00 per month service charge if payments are not received.

Signature__________________________________ Date____________________

(over please)

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Nova Chiropractic

Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Nova Chiropractic. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Diane Smith.

Nova Chiropractic also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached. Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. ________ (please initial)

If you have any questions regarding this notice or our health information privacy policies, please contact:

Diane Smith
You can reach the Privacy Official at: Nova Chiropractic, 844 Jackson St, Santa Clara, CA 95050, 408-249-0382
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: ____________________________ (you may receive PHI through email)

Print Patient Name: _______________________________

Signature Patient/Personal Representative: ____________________________

Relationship of Personal Representative: ______________________________

Date of Signature: __________________

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and
the reasons why the acknowledgement was not obtained.

□ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
□ Other: ____

Staff Signature: ____date: ______________