Sports & Spinal Injury Clinic, LLC

6634 Lake Otis Pkwy #A, Anchorage, AK 99507
Phone (907) 522-3511; Fax (907) 522-8551

Office Policies

WELCOME!

Thank you for choosing one of the finest health care clinics in Alaska! Our holistic approach uses the latest chiropractic techniques, massage and myofascial therapies, individualized exercises, and physical therapies (hot and cold packs, electrical muscle stimulation, ultrasound, inferential, etc.) to restore and improve your health in the shortest time possible. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between you, our patient, and us. Your health is our #1 priority!

Office Hours & Appointments

Our clinic is open Monday, Wednesday, Friday from 9:00am-6:00pm and Tuesday, Thursday from 9:00am-7:00pm, with 5:30pm-7:00pm being by appointment only Monday through Friday. Please arrive early or on time for your appointment. If you are late, it may result in a shorter treatment session or possible rescheduling. If you know you will be more than 5 minutes late, please call first. **We call to confirm your appointment the day before your appointment so an authorization will be needed to leave a message for your appointment and any insurance issues that might arise**.

If you need to cancel or change an appointment, please let us know at least 12 hours in advance. This makes it possible for us to give the appointment time to another patient who may be on the waiting list. **If you do not show up for your appointment or if you give us less than 12 hours notice that you will not be able to keep an appointment, *YOU* will be *CHARGED* the *FULL AMOUNT not the Insurance company.*** (Please note most medical offices require a 24-hour notice).

Payments/Discounts

Our policy requires payment in full for all services rendered at the time of visit unless prior arrangements have been made. If your account is not paid within 90 days of the date of service, you may be responsible for late fees of **$25** per month going back to the first month of treatment. Please address any financial concerns to us as soon as possible. If you have health insurance that you believe may cover chiropractic, we can verify your insurance coverage for you. Please note, there is no guarantee of coverage as coverage and benefits are not determined until the claim is received and processed. As a courtesy to you, once your eligibility and coverage is determined, we will file all insurance claims for you to the extent that your policy permits, however you are ultimately responsible for payment whether your insurance pays or not. *Discounts on liens will/can be accepted only if ALL parties involved accepts the same discount and proof is available including the Attorney.* A discount will NOT be given even if the Attorney pays you directly to have you pay for your own medical expenses to get out of him/her having to discount their fees/amount.

Children

Children and infants are welcome as patients or when accompanied by parents. For chiropractic treatments, it is usually possible for a staff person to babysit, but for longer treatments such as exams or massages, please arrange for your own babysitting.

Referrals

After we help you, please tell others. Our way of showing you our appreciation, after ***3 referrals*** either for the Doctors or at least 1 1-hour massage and they name you, you will receive a gift certificate for a ***1-hour massage***.

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Patient Name: _____
Last First Middle
Name You Prefer to be called: _____ SS#: _____
Date of Birth: _____/_____/_____ Gender: M / F Email: _____
Mailing Address/City/ST: _____ Zip: _____
□Home Phone #: _____ □Cell Phone #: _____ □Work Phone w/ext.: _____
(Please check all box(es) above where detailed messages regarding your appointment or billing issues can be left.)
Occupation: Student / Clerical / Laborer / Education / Sales / Other: _____
Employer: _____ How long?:_____
Employer's Address/City/ST: _____ Zip _____
Other Phone #'s: _____ Marital Status: Single / Married / Divorced / Widowed / Separated
Spouse's Name: _____ Spouse DOB: _____ Spouse Cell #: _____
Spouse's Employer: _____ Phone Wk #: _____
Spouse SS#: _____ Emergency Contact: _____
Emergency Contact Relation: _____ Phone #: _____

I HEARD ABOUT THIS CLINIC FROM (Name if app): _____

Payment (Circle one) **Auto • Cash/Check/CC • Health Ins • MC • Personal Injury • VA • Work Comp**
Do you have Medicare? Yes / No Is Medicare your Primary or Secondary? _____

Person ultimately responsible for account (If patient is a dependent)
Name: _____ SS#: _____ DOB: _____
Mailing Address/City/ST: _____ Zip: _____
Home #: _____ Cell #: _____ Relationship to Patient: _____
Employer: _____ Work # _____

Primary:
Insured Name: _____ SS#/ID: _____ DOB: _____
Insurance Co.: _____ Group #: _____ Plan #: _____
Ins. Address/City/ST: _____ Zip: _____
Phone #: _____ Insured's Employer: _____

Secondary:
Insured Name: _____ SS#/ID: _____ DOB: _____
Insurance Co.: _____ Group #: _____ Plan #: _____
Ins. Address/City/ST: _____ Zip: _____
Phone #: _____ Insured's Employer: _____

I certify that I am the patient or legal guardian listed above and consent to the collection and use of the above information to this office of chiropractic. I fully understand when the insurance company verifies my benefits it is not a guarantee or authorization to pay on claims submitted and that health / accident insurance policies are an arrangement between an insurance carrier and myself. I agree to pay my patient portion, plus any balance the insurance does not reimburse for, at each visit or when I receive the outstanding bill. I agree to pay/settle any denied and unpaid claims over and above insurance payments. I further understand all claims submitted by this office are my responsibility and may require my participation to settle regardless of my insurance or assignment of benefits. I also authorize the release of any information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I also understand that if my bill is not paid within 90 days of the date of service and no financial arrangements have been made, a $25 per month charge from the first month will be added to my bill. I agree that this office will file my claim form, and that Health Care Benefits or Medical Reimbursement from a Third-Party Payer, if I do not have med-pay with my insurance, will be made directly to **Sports & Spinal Injury Clinic, LLC** otherwise payable to me, unless the account is previously paid in full. I understand that *a discount on liens will/can be accepted only if ALL parties involved accepts the same discount and proof is available, including the **Attorneys***. I also understand that a discount will NOT be given even if the Attorney decides to pay me directly and have me pay my medical expenses. I authorize **Sports & Spinal Injury Clinic, LLC** to perform any necessary diagnostic testing, ie. vital signs, range of motion, palpation, muscle strength, postural analysis, basic neurological, orthopedic testing, etc., needed during diagnosis and treatment. I understand that pain syndromes can be caused by conditions (such as tumors, etc.) which may be visualized by x-rays, however, I have decided that if the Doctor determines X-rays are not necessary for my condition that I agree also to not have x-rays and do not hold anyone associated with the **Sports & Spinal Injury Clinic, LLC** responsible for such pathology and authorize this office and its staff to examine and treat my condition as the doctors see fit. **I also understand that if I do not show for an appointment or if I give less then 12 hours notice to cancel or reschedule an appointment, that I am responsible for the charges of that appointment and not my insurance**. I have read and understand the included information, certify it to be true and accurate to the best of my knowledge, understand it is my responsibility to inform this office of any changes in my medical status and agree to these terms. I also agree and understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature of Patient (or Guardian) _____ Date_____

Sports & Spinal Injury Clinic, LLC

Reason For Visit Form

NAME: _____ID#: _____ DOB: _____ M / F DATE: _____

The reason for this visit is/Major complaint(s): 1._____ 2._____ 3._____ 4._____

Date each condition began? 1._____ 2. _____3. _____4. _____

What caused your condition? 1._____2. _____3. _____4. _____

When does it hurt? AM / PM #_____ Constant / Intermittent # _____ Daily / Weekly / Monthly # _____

Describe the quality/character of the pain of each complaint with its #: _____

Does it radiate to another part of your body? If so, where?: _____

Is condition getting: ❑ Worse? #_____ ❑ Better? #_____ ❑ Unchanged? #_____ ❑ Comes/goes? #_____

What helps your condition? 1._____2. _____3. _____4. _____

What aggravates your condition? 1._____2. _____3. _____4. _____

Associated Symptoms (Ex: headache, difficulty breathing, bowel/bladder dysfunction, etc.) _____

_____

Level of physical activities now from 1 to 10? (1 = Sedentary & 10 = Active) _____ Level before? _____

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine? If any, how _____

_____

Have you been treated by another Physician for **this** condition? ❑ Yes ❑ No If so, when and where?

Name of Hospital and/or Attending doctor? _____

_____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S. ❑ N.D. ❑ Other _____

How did you get there? ❑ Ambulance ❑ Private transportation Were X-rays taken? ❑ Yes ❑ No

Was medication prescribed? ❑ Yes ❑ No If so, what? _____

What's been done for this condition?: _____

_____

To evaluate the effect that continuing work will have on your recovery please complete the following: (If applicable)

Have you been able to work since this injury? ❑ Yes ❑ No # of hours in normal workday? _____

Maximum weight you are required to lift? _____

Prior to injury were you physically capable of working on an equal basis with others your age? ❑ Yes ❑ No

While in recovery, is there any light duty work you could request? ❑ Yes ❑ No ❑ N/A

Please describe your job/work: _____

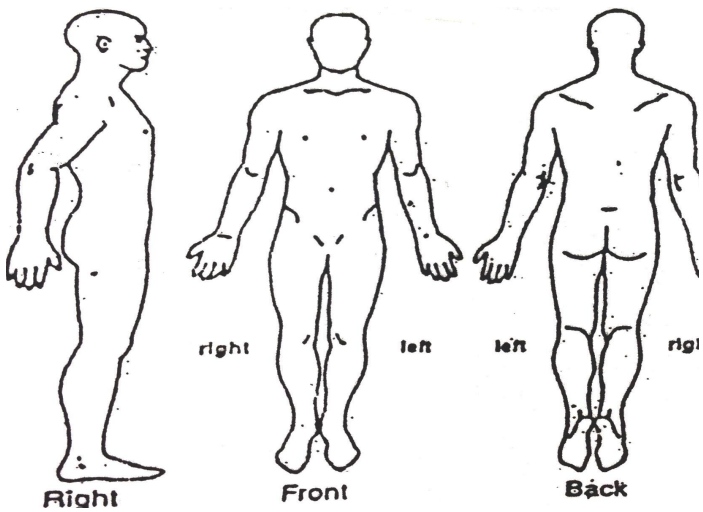
_____

Please check any of the following activities that cause pain or discomfort.

❑ Sitting / Standing
❑ Kneeling
❑ Running / Walking
❑ Lovemaking
Working
❑ Bending Forward / Backward
❑ Pulling / Pushing / Reaching
❑ Lying on Back / Side / Stomach
❑ Turning Head / Back
❑ Twisting
❑ Sports
❑ Lifting

Please circle all **area(s)** of injury or discomfort and mark all areas with the appropriate symbols from below.

P = Pinching
NN = Numbness
BB = Burning
AA = Aching
SS = Stabbing
PP = Pins & Needles



Sports & Spinal Injury Clinic, LLC
Health History Form

NAME: _____ID#: _____ DOB: _____ M / F DATE: _____

Please check any of the following you have or have had.

- ❑ Alcohol / Drug Abuse
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones / Joints
- ❑ Artificial Valves
- ❑ Asthma / Difficulty Breathing
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Congenital Heart Defect
- ❑ Diabetes / Tuberculosis
- ❑ Disc Herniation _____
- ❑ Emphysema / Lung Disorder
- ❑ Fainting / Seizures / Epilepsy
- ❑ Fibromyalgia
- ❑ Frequent Neck Pain
- ❑ Frequent / Severe Headaches
- ❑ Glaucoma
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery / Pacemaker
- ❑ Hepatitis
- ❑ High / Low Blood Pressure
- ❑ HIV+ / Aids
- ❑ Kidney Problems
- ❑ Lower Back Pain
- ❑ Lupus
- ❑ Mitral Valve Prolapse
- ❑ Psychiatric Problems
- ❑ Rheumatic Fever
- ❑ Scoliosis
- ❑ Shingles
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Ulcers / Colitis
- ❑ Venereal Disease
- ❑ Other _____

Please list any medications (prescriptions and non-prescriptions) you are currently taking.: _____
_____
Please list any other serious medical condition(s) you have or ever had: _____
_____
Please list anything that you may be allergic to: _____
_____
List previous surgeries/treatments with dates: _____
_____
List any **past** serious accidents/injuries/illnesses with dates: _____
_____
List any fractures/broken bones: _____
_____
Family Health History: _____
_____
Other complaints: _____
_____
Do you smoke/chew tobacco? If so, how much? _____ How long? _____
Do you drink alcohol / drugs? If so, how much? _____ How long? _____
Do you consume caffeine on a regular basis? ❑ Yes ❑ No / How much? _____
Describe your dietary habits: _____
_____
Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports
Is your mattress supportive? ❑ Yes ❑ No Do you exercise? ❑ Rarely ❑ Frequently ❑ Routinely
Do you sleep on your ❑ Back ❑ Left side ❑ Right side ❑ Stomach
What types of exercise do you do? _____
_____
Any other relative information: _____
Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

For women: Pregnant? ❑ Yes ❑ No / How far along? _____ Nursing? ❑ Yes ❑ No
Birth Control? ❑ Yes ❑ No If so, what? _____

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To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Treatment

As part of the treatment, you are consenting to the following procedures:

spinal manipulative therapy	therapeutic ultrasound	hot/cold therapy
massage/myofascial release	exercise and stretches	traction
EMS (electronic muscle stimulation)		

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle stain, cervical myelopathy, costovertebral strain and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. For comparison's sake, according to the U.S. National Weather Service, the odds of being struck by lightning in your lifetime are one in 6250 and your odds in any given year for chiropractic adjustment causing a stroke is one in 750,000. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Steroid injections
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

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The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment.

_____ **Dated:** _____
Patient's Signature

_____ **Dated:** _____
Signature of Parent or Guardian
(if patient is a minor)

Please sign below AFTER talking with the Doctor. Thank you.

I have discussed it with Dr. Matthew Huettl/Dr. David Prentice and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ **Dated:** _____
Patient's Signature

_____ **Dated:** _____
Signature of Parent or Guardian
(if patient is a minor)

_____ **Dated:** _____
Doctor's Signature

If patient is a minor:
I, _____, hereby affirm that I have the legal right to select and authorize health care services for the minor child, _____, date of birth, _____. Unless revoked in writing, this consent remains in effect until my child is 18 years of age or until the date of _____ of _____ 20_____. I also give permission for my child to be medically evaluated and treated by Sports & Spinal Injury Clinic LLC, in my absence. _____ (Guardian Initials)

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INDIVIDUAL FINANCIAL POLICIES

We have prepared the following financial policy to help our patients determine their responsibility for payment of services rendered at our office and that you are ultimately personally responsible for all payments regardless of whether or not this office accepts insurance assignment. Please determine the statement that applies to you, initial each page letting us know that you read it, and then sign at the bottom. Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

Payment is expected at time of service unless prior arrangements have been made.

Phone Quotes

Phone quotes from your insurance company does not approve treatment nor do they guarantee payment. Any unpaid portion is your responsibility.

Health Insurance - Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

It is our policy that if you have health insurance that you believe may cover chiropractic; we will verify your insurance coverage for you. Once your eligibility and coverage are determined we will file all insurance claims for you to the extent that your policy permits, however you are ultimately responsible for payment whether your insurance pays or not. Please note, there is no guarantee of coverage as coverage and benefits are not determined until the claim is received and processed. It is against the law to write-off or to not collect your deductible, co-payment, co-insurance, any non-covered supplement, supplies or services so you are also responsible for paying any amount not covered by your insurance at the time they are rendered.

OR

If you have insurance coverage and wish to bill your own insurance instead of us, we require that you pay 100% of the services rendered at the time of each visit. We will provide you with a receipt with the necessary billing information, which you can send to your insurance carrier for reimbursement.

Non-Insured/Private Pay

We request 100% of the first visit be paid at the time of the first visit. All future visits must also be paid 100% at the time of service. If your financial situation requires special arrangements, please speak with the Billing Coordinator/Specialist.

Workers' Compensation - Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

Chiropractic services are covered by Workers' Compensation law, and you should be covered 100%, if your employer is aware that you were injured on the job, you have completed the required papers with your employer, your employer has no objection to your receiving care here, and you are covered by Workers' Compensation Insurance. You are responsible for non-covered items such as supplements and supports. These items are to be paid for at the time they are received. We can bill the insurance for you after you pay for them and if the insurance pays, we will reimburse you. IF YOU ARE DENIED, YOU WILL BE RESPONSIBLE FOR ALL BILLS INCURRED.

Medicare

Our doctors are Participating Providers with Medicare; therefore, we are required to bill Medicare for services. MEDICARE WILL ONLY PAY FOR MANIPULATION OF THE SPINE AS LONG AS IT IS NOT CONSIDERED MAINTENANCE. Medicare does require that you pay for your X-rays, examinations, supplements, physical therapy, massage, and any other non-covered services at the time they are rendered unless you have a secondary insurance, NOT a supplemental insurance. You will also be required to pay an annual deductible and a small co-payment ranging from $6.50-$35.00 depending on your policy with Medicare and cannot and/or will not be written off. That is against the law. The amount of the deductible changes every year, and we will try to inform you how much it is each year. If you have a true secondary insurance policy that may cover chiropractic, we can/will verify coverage and then bill them for you if Medicare does not. Please note, there is no guarantee of coverage as coverage and benefits are not determined until the claim is received and processed. Supplemental insurance will not cover anything Medicare does not, so you will be responsible for any balance Medicare will not cover. Medicare will send payment directly to our office. You will also be required to pay all visits in full once Medicare stops paying this clinic.

Massage Therapy/Rolfing

You will be required to pay in full, your co-payments at the time of service and any balance remaining your insurance does not cover.

Late Fees

If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for late fees of $25 a month going back to the first month. Please address any financial concerns to us as soon as possible.

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Automobile Accident - Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

Services rendered are normally covered 100% provided there are medical payments (referred to as "med-pay") coverage on the automobile that you were in at the time of the accident. Said coverage usually has a limit of responsibility from 1 to 3 years from the date of accident, or until the available benefits are exhausted.

Should there have been another vehicle involved in the accident, and it would appear this is a liability claim, since the other party caused the accident, we would be happy to complete whatever papers are necessary to help you settle your claim. If the other vehicle that was involved was found to be liable and you would like for them to pay for your care in our office, you need to be aware that their insurance will not pay us for your visits until the claim is settled. They could also pay you directly, and most likely not pay you until the case is settled, which you would then owe us.

THEREFORE, the following is our policy regarding payment for services:

1. We will bill the insurance carrier of the vehicle you were in at the time of the accident using the "med-pay" coverage before billing the other insurance company if it is available.
2. If no "med-pay" coverage is available on the vehicle you were in at the time of the accident or it has been exhausted we will bill your private or group health insurance if it covers chiropractic. You will be responsible for paying for your deductible, co-payments, and non-covered services at the time of service. If you have an attorney representing you in this case payment can be deferred in most cases until the case is settled.
3. If no medical benefits are available to you through med-pay or health insurance but you have an attorney representing you, we will wait for payment until the case is settled, however, we must have the attorney's name, address, phone number, and we will have to verify that they are representing you. The attorney must also sign and return a lien form to this clinic within 10 days of receipt. If you are being treated on a lien basis a co-pay of $25.00 is required at each treatment. If you change attorneys, we must be informed immediately, and they must also sign and return the lien form to this clinic within 10 days of receipt and confirmed of representation.
4. If you do not have med-pay coverage, health insurance that covers chiropractic, or an attorney, you will be required to pay for all services at the time you receive them. If you require assistance in finding an attorney, please ask us. We will provide you with the name of at least 1 attorney who supports chiropractic care. If you do get an attorney, we must have confirmation from the attorney that is representing you within 10 business days of your initial visit. Payment is still expected in full at time of service until the attorney representing you has been confirmed and all lien papers are signed.

NON-VEHICULAR ACCIDENT - Regarding ANY DISCOUNTS: Please see *#10 on page 3*.

If you were involved in a non-vehicular PI case (slip or fall in a restaurant, parking lot, house, etc…) and the liability carrier has accepted liability for your injury and agreed to pay us directly on a month-to-month basis, we will bill the liability insurance carrier for you.

If the liability carrier has not accepted liability or will not pay us directly, our policy regarding payment is as follows:

1. We will bill your private or group insurance if it covers chiropractic. You will be responsible for your deductible, co-payments, supplies and non-covered services at the time of service. If you have an attorney representing you in this case, payment can be deferred in most cases until the case is settled except for supplies, however, we must have their name, address, phone number, and are able to verify that they are representing you. The attorney must also sign and return a lien form to this clinic within 10 days of receipt. If you are being treated on a lien basis a co-pay of $25.00 is required at each treatment.
2. If you do not have health insurance that covers chiropractic in our office, but you have an attorney representing you, we will wait for payment until the case is settled, however we must have their name, address, phone number, and are able to verify that they are representing you. The attorney must also sign and return a lien form to this clinic within 10 days of receipt. If you are being treated on a lien basis a co-pay of $25.00 is required at each treatment.
3. If you do not have health insurance that covers chiropractic or an attorney, you will be required to pay 100% of services at the time you receive them. If you require assistance in finding an attorney, please ask us. We will provide you with the name of at least 1 attorney who supports chiropractic care. We must have their name, address, phone number, and are able to verify that they are representing you within 10 business days of your initial visit. Payment is still expected in full at time of service until the attorney representing you has been confirmed and all lien papers are signed.

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We believe this is a clear definition of our financial policy and it will allow us all to continue to concentrate on the most important issue of your health and well being.

IT MUST BE UNDERSTOOD:

1. The **privilege** of insurance assignment begins when our office receives and confirms your insurance information.
2. All deductible and/or copay payments **MUST** be made prior to insurance submittal.
3. To assist you, our office will confirm your insurance coverage to determine exactly what Chiropractic coverage is available to you under your policy. **Please note, there is no guarantee of coverage as coverage and benefits are not determined until the claim is received and processed**.
4. All deductibles, co-insurance/co-payments, non-covered supplements, or supplies are payable when service is rendered or at the end of each week with prior approval. A $300 balance must not be exceeded by any patient.
5. Since **we do not own your policy** and since from time to time, we may have difficulty in collecting from your insurance company, and the insurance assignment is a privilege, they may terminate at any time. Of course we will try to give you ample notice and ask that you act in your own behalf with **your** insurance company.
6. This office **does not** promise that an insurance company will pay for the usual and customary charges of this office, nor will this office enter any dispute with an insurance company over reimbursement or the amount of reimbursement or write-off any portion.
7. If your insurance considers any charges as: mutually exclusive, not medically necessary, exceeds limitations either yearly or daily, or multiple therapy procedure reduction, we will not write those off. You are and will be responsible for those charges.
8. Should you discontinue care for any reason, other than discharge by the doctor, all balances due will become immediately due and payable in full by you, regardless of any claims submitted.
9. When making a health care decision it is important to remember that you, the patient, are ultimately financially responsible for any services rendered.
10. Under any circumstances, if you are denied coverage for any reason by any of the above, you will be responsible for all bills incurred.
11. If you have an attorney for your Auto/PI case, your attorney must return a signed lien to us with accepting to pay us when the case is settled within 10 days of your first visit. However, if they do not pay us for any reason, you are ultimately financially responsible. *A discount on liens will/can be accepted only if **ALL** parties involved accepts the same discount and proof is available, including the **Attorney***. I also understand that a discount will NOT be given even if the Attorney decides to pay me directly and have me pay my medical expenses.
12. **Late Fees -** If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for late fees of $25 per month going back to the first month of treatment. Please address any financial concerns to us as soon as possible.
13. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions regarding your health care or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.
14. Due to the nature of insurance processing, I understand that I am liable for any remaining balance that the insurance does not cover. This is up to and including for the past three (3) or more years.

I have read and understand the above three (3) pages of this financial policy . I also understand that this financial policy is valid for three (3) years or until the case is settled, whichever is longer, and that I will have to re-sign another agreement if a new case is started. I also understand that if I want a copy of this policy, I will ask for a copy and one will be made available to me.

SIGNATURE: _____ **PRINTED NAME:** _____

DATE: _____

Revised 6/27/2021

Sports & Spinal Injury Clinic, LLC

Dr. Matthew K. Huettl and Dr. David Prentice

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Phone: (907) 522-3511; Fax: (907) 522-8551

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Practice (the "Practice"), in accordance with the Federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purpose of: (a) **Treatment** - To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan. (b) **Payment** - To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether it will or won't cover the treatment expense. (c) **Health Care Operations** - To operate in accordance with applicable law and insurance requirements and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

OTHER EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PROTECT HEALTH INFORMATION

(a) **Advice of Appointment and** Services - The Practice may, from time to time, contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you or the post office; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone. (b) **Directory/Sign-In Log** - The Practice may maintain a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log location is positioned where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's office. (c) **Family/Friends** - The Practice may disclose to a family member, other relative, a close friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply; (i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure. (ii) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosures is in your best interest and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose and PHI without your consent or authorization in the following instances: (a) **De-identified Information** - The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you. (b) **Business Associate** - The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assist the Practice in understanding some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies. (c) **Personal Representative** - The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care. (d) **Emergency Situations** - The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible. The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in emergency situations. (f) **Abuse, Neglect or Domestic Violence** - The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm. (g) **Health Oversight Activities** - The Practice may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or other activities relating to the community's health care system. (h) **Judicial and Administrative Proceeding** - The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena. (i) **Law Enforcement Procedures** - The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct. (j) **Coroner or Medical Examiner** - The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you to determining your cause of death. (k) **Organ, Eye or Tissue Donation** - The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs. (l) **Research** - The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities. (m) **Avert a Threat to Health or Safety** - The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat. (n) **Specialized Government Functions** - The Practice may use and disclose PHI when authorized by law regarding certain military and veteran activity. (o) **Workers' Compensation** - The Practice may use and disclose PHI if you are involved in a Worker's Compensation claim to an individual or entity that is part of the Workers' Compensation system. (p) **National Security and Intelligence Activities** - The Practice may use and disclose PHI to authorized officials with necessary intelligence information for national security activities. (q) **Military and Veterans** - The Practice may use and disclose PHI if you are member of the armed forces, as required by the military command authorities.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to: (a) Revoke and Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. (b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Pricey Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. (c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests. (d) Inspect and copy your PHI as provided you by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situation that are defined by law, the practice may deny your request, but you will have the right to have the denial reviewed as set forth moiré fully in the written denial request. (e) Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement. (f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164-528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before January 2013. The request should indicate in the form you want the list (such as paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. (g) Receive a paper copy of this Privacy Notice for the Practice (as provided by Privacy Rule Section 164.520(b0)(1)(iv)(F)) upon request to the Practice's Privacy Officer. (h) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing. To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows: Sports & Spinal Injury Clinic, LLC 6634 Lake Otis Pkwy #A, Anchorage, AK 99507, (907) 522-3511.

PRACTICE'S REQUIREMENTS

The Practice: (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. (b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law. (c) Is required to abide by the terms of this Privacy Notice. (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all your PHI that it maintains. (e) Will distribute any revised Privacy Notice to you prior to implementation. (f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is in effect as of April 15, 2003.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

X_____ _____

Signature of Patient **Date**

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of this Notice could not be obtained because:

- Patient refused to sign
- Communication barrier prohibited obtaining acknowledgement
- Emergency circumstances
- Other

Details:

_____ _____

Signature of Practice **Date**