



## Patient Policies and Contract for Services

The purpose of this agreement is to allow us to more completely serve you and to get the best test results in the shortest amount of time. It is our experience that those patients who adhere to the following agreement get the best results.

### **Payment of Bills**

Patient will be charged for services at the normal and reasonable rates charged by this office for the specific service. The Patient always has the ultimate responsibility to meet their financial obligations with this office. Payment is expected at the time of service. Any modifications to this payment policy must be addressed with our staff. If any alternative arrangement is made with you, i.e. doctor's lien, billing of insurance companies, etc, you will be expected to cooperate with this office to effect the full payment of your services through this alternative arrangement.

For insurance (and Medicare) payments: By entering into this patient contract with Dr. C.K. McClellan, you agree to assign all insurance payments related to your services and authorize direct payment to this office. Amounts received from the insurance provider will be applied towards your account; however, you will continue to be liable for any unpaid amounts. You will be expected to provide us complete information regarding your insurance coverage, sign any documents that need to be signed and you will be expected to bring to our office any payments sent to you immediately. The patient further authorizes benefits be made on behalf of the patient pursuant to the Social Security Administration or Medicare directly to Dr. C.K. McClellan, Jr., D.C. or any appropriate agent.

For Doctor's Lien: You will be expected to provide us with the name, address and phone number of the attorney, sign an doctor's lien, provide for us the case name and number and any other information requested regarding your case. In addition, by signing a doctor's lien, you are also giving us permission to contact your attorney's office and discuss the status of the case. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

If you find that you cannot fulfill the agreement you've made with us, please advise our staff immediately so new arrangements can be made. If you do not assist us in these alternative arrangements and we are compelled to invoice you for the remaining amount due you will be billed an addition \$5.00 service fee. The balance of your account will be due and payable within ten days of receipt of your statement. If the balance is not satisfied within ten days you will be billed a \$15.00 late fee, 1 1/2% interest per month and a monthly service fee of \$5.00 until such time as the balance is satisfied.



Attorney's fees for collection: In case of any default in the payment arrangements made between you and our office, this office will seek the assistance of legal counsel for the purposes of collection. By entering into this agreement, you are acknowledging that in the event that it becomes necessary to obtain the services of legal counsel or should it be necessary to file a civil suit for collection, the patient (or other responsible party, if applicable) will be responsible for the payment of all court costs, all reasonable attorney's fees and all other collection fees. Reasonable attorney's fees shall be calculated at 1/3 of the balance due or \$1,500 (one thousand five hundred dollars) whichever is greater.

### **Consent to Medical Treatment**

By entering into this contract, you are consenting to any examination (x-ray or otherwise) including but not limited to physical examination, chiropractic procedures or treatments, photographs and/or other services rendered the patient by members of the staff, their representatives and/or associates, and clinic employees under the instruction of the physician. The undersigned also consents to observations, examinations, diagnostic or other procedures by personnel in training or by other appropriate persons permitted by the attending physician and allowed by this office.

### **Communication to Patient of Medical Information**

The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning need for services, the purpose of the Patient entering the clinic, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine or chiropractic is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

### **Release of Information**

C.K. McClellan, Jr., D.C. may disclose any and all records of the patient to any person or organization which is or may be liable or responsible for payment of all or part of the charges, including, but not limited to, insurance companies, medical or hospital service companies, workman's compensation carriers, attorneys, employers, Social Security Administration and welfare funds.

### **Office Hours and Appointments**

All evaluations, examinations and treatments are by appointment only. Your doctor has specific office hours. The receptionist will schedule your appointment accordingly.

### **Extended consultations - Wellness Workshops**

It is mandatory that all patients attend at least 1 in-office Workshop. This consultation explains how the body functions, things you can do to help yourself at home, how Chiropractic works and how results are produced. Please be encouraged to bring family and friends at no charge. The extended consultation is in part a workshop and we ask you to bring a partner to assist in the procedures we will teach. Please inform our office at least one week in advance, as to when you will be attending.

### **Progress Evaluations and Re-Examinations**

During your course of care, progress evaluations and check-ups may take place. The fee for these services should be paid according to the payment agreement made with our office.



**Patient Communication**

We are here to serve you. Please speak with the doctor or anyone of our staff about any upsetting matter. We see your comments as helping us to help you and others.

**Privacy Policy**

This office has a written privacy policy, which has been provided to you. If you have any questions related to this policy, please bring them to our attention.

*Receipt of privacy policy:* \_\_\_\_\_

Patient's Signature

X \_\_\_\_\_ Date \_\_\_\_\_

Other Responsible Party

X \_\_\_\_\_ Date \_\_\_\_\_

I have read and/or explained the above information and all parts of this form outlining all stated conditions to the patient or the patient's responsible representative and the patient/responsible party appears to fully understand these conditions as stated:

\_\_\_\_\_  
Employee of Chiropractic Nashville



## **Notice Of Privacy Practices**

*Effective Date: MARCH 1, 2004*

### **Please Review Carefully**

This notice describes how medical information about you may be used and released and how you can get access to this information.

This notice applies to all records generated by your provider, physician, office medical or billing personnel, or Business Associates.

➤ **OUR RESPONSIBILITIES**

We are required by law to maintain the privacy of your health information and provide a description of our privacy practices. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction.

➤ **USE AND RELEASE OF MEDICAL INFORMATION**

We may use and release your medical information (clinical and billing) for:

- Payment, Treatment, Healthcare Operations
- Business Associates
- Appointment Reminders
- Treatment Alternative Education
- Health-related Benefits or Services
- As required by law to State/Federal Agencies
- Family or friends involved in your care
- Entities assisting in Disaster Relief

➤ **YOUR HEALTH INFORMATION RIGHTS**

Although your health record is the physical property of the healthcare provider, you have the Right to:

- Access Information
- Request Amendments
- An Accounting of Disclosures
- Request Privacy Restrictions
- Request Alternate Communication
- File Complaints
- Obtain a Detailed Copy of this Notice

Please refer all requests to the Office Manager.

➤ **Access:**

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but there are limited circumstances in which we can deny your request. These denials must be provided to you in writing, and you may request a second interview in writing.



➤ **Amend:**

If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend, or add to the information. You have the right to request an amendment for as long as the information is kept by or for the physician. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial in writing.

**AN ACCOUNTING OF DISCLOSURES:**

You have the right to request an accounting of disclosures of medical information about you. This does not include disclosures for treatment, payment, operations, or to you or your authorized representative.

**Request Restrictions:**

You have the right to request a restriction or limitation on the medical information we use or release about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we release about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request**, but will do so if the request is reasonable.

**Request Confidential Communications:**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. **We reserve the right to contact you by other means** and at other locations if you fail to respond to communications from us.

➤ **A PAPER COPY OF THIS NOTICE:**

You have the right to receive a detailed paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

➤ **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Official or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

*YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.*

➤ **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or release medical information about you, you may withdraw that permission, in writing, at any time.



➤ **CHANGES TO THIS NOTICE**

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the practice and include the effective date. We can provide additional copies of the notice when you check in for future appointments, at your request.

If you have any questions about this notice, would like to request a form or have any complaints, please contact:

Courtney Peck  
Office Manager  
(615) 292-2797