John Zimmerman, D.C.

2629 Redwing Road, Suite 200. Fort Collins Colorado 80526
Phone (970)672-0789 . Fax (970)672-0884

PRACTICE POLICIES

Thank-you for choosing us to participate in your health care. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial policy, which we require you to sign prior to any treatment.

Financial Policy: Payment is due in full at time of service, including co-payments and/or deductibles. We accept cash, checks, money orders, Discover, Visa, and Master Card. We ask that you please keep your account current. Any balance that remains unpaid after 30 (thirty) days may begin to accrue late charges. If your account remains in a delinquent status for over 3 (three) months it can be placed with our collection agency and you waive your right to confidentiality. A delinquent account can be the basis for termination of your care from our office. There will be a $50.00 charge for all returned checks and we will no longer accept personal checks from you as a form of payment.

Insurance: Thank you for being responsible and taking the time to know the terms and coverage of your insurance policy prior to appointments with this office or with locations we refer you to. A discount will be given to patients without insurance or with non-participating insurance who pay in full at the time of service.

In- Network: We are contracted with most major insurance companies. It is your responsibility to know if you have chiropractic coverage and what the benefits are for treatment. It is also your responsibility to provide us with accurate and current insurance information: we cannot bill insurance for you unless you bring in all current insurance information.

Out-of- Network: If we do not participate with your insurance, we require payment in full at the time of service. We will provide you with a copy of your super bill to send to your health plan for possible reimbursement. Our practice is committed to providing the best treatment possible to our patients and we believe our charges are reasonable for this area. You are responsible for full payment regardless of any insurance determination of usual and customary rates. In addition, some and perhaps all of the services provided may be determined "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance.

Paperwork/Information verification: We understand that filling out paperwork or verifying your information upon "check in" may seem repetitive and unnecessary. Please understand that in order to ensure our information is accurate and up to date and to meet federal regulations, we do have to ask for your cooperation with keeping our records accurate and current. Your refusal to fill out paperwork/verify information or refusal to fill out paperwork completely and accurately will be interpreted by us as a decision on your part not to be seen at our office and may result in termination from our practice

NOTICE OF PRIVACY PRACTICES
(HIPAA)

This summary describes how we use and share information about you. This summary describes how you may see and get copies of this information.) This notice includes all occupants of John Zimmerman, DC.

OUR COMMITMENT TO RESPECT PRIVACY:

John Zimmerman, DC is required to:

- Keep your information private
- Let you know if we cannot do what you have asked us to do with your information.
- Try to reach you at another location or phone number, if you ask us to do so.
- Use and/or give out your information as listed below and as the law permits, unless we have your permission to do more.

WE MIGHT USE OR SHARE INFORMATION ABOUT YOU FOR:

- Treatment: Such as when our providers and employees discuss your care.
- Payment: Such as when we bill your insurance company for services provided to you.
- Other Ways: Such as when we share information to protect the health and safety of others or you; when we send disease reports to county and state health offices as required by law; when we provide information to researchers, organ donation groups, or funeral directors; and when we respond to court requests. We may also send you appointment reminders, greeting cards, and newsletters.

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NOTICE OF PRIVACY PRACTICES (HIPAA) CONTINUED

HOW YOU MAY SEE AND GET COPIES OF THIS INFORMATION:

You have the right to:

- Ask for restrictions on the ways we use and give out your information. However, we are not required to do what you ask, where the law requires otherwise.
- Get and inspect a copy of your health record. Add information to your health record. Ask that your health information be sent to a different address or that we call you at a different phone number
- Change your mind if you told us we could use or share your information for reasons other than those listed above.
- Get a list of the times we gave out your information (this will be a list of the times the law requires us to keep a record of releasing your information). As we serve our clients, we may modify what we do with your information. If we make a change, we will give you a new notice the next time you visit us. You may call or write us to inquire about any changes.

COMPLAINTS: If you think your privacy rights have been violated, you may complain to John Zimmerman, DC. You will not be mistreated for filing a complaint.

PLEASE SELECT ONE OF THE FOLLOWING TWO OPTIONS THAT APPLY TO YOU AND INITIAL, TO INDICATE YOUR SELCTION.

FINANCIAL POLICY: FOR INSURANCE PATIENTS

ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION

I Hereby assign to John Zimmerman, DC all coverage or other benefits available under any government program, insurance policy, worker's compensation claim, or other benefit program, and I direct that benefits be paid directly to John Zimmerman, DC. I agree that John Zimmerman, DC may receive benefits directly, which will discharge the insurer or benefit program to the extent of such payments. I agree to pay promptly and fully all charges for services provided by, according to the rates and terms of my insurance company. I hereby personally obligate the patient and myself, if signing as a spouse of the patient or as a parent or guardian of a minor patient, to payoff all such charges. No extension or forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collection of such charges shall waive or release these personal financial obligations** I hereby authorize John Zimmerman, DC to release information as necessary to obtain benefits from this policy. If needed, I also authorize this clinic to file a complaint with the Colorado division of insurance on my behalf for nonpayment of claims by my insurance company.

INITIAL _____

-OR-

FINANCIAL POLICY: FOR SELF PAY PATIENTS

SELF PAY AGGREEMENT

I am not covered by any form of health insurance or am covered by an insurance company that is non- par with this facility and will be considered a self-pay patient. I understand that I will receive a discount for paying in full at the time of service. I understand that payment in full is due at the time of service unless prior arrangements have been made with the billing department.

INITIAL _____

I have read, understand and agree to all of John Zimmerman, *DC's* practice policies, privacy practices (HIPAA), and the financial Policy. I understand that this authorization will remain in effect for as long as I, and/or my dependent, remain a patient. I understand that these may be subject to change periodically without notice. I verify that all the above information is true and accurate to the best of my knowledge.

NAME:

DOB:

DATE:

SIGNATURE: