THE NEURO CLINIC
CHIROPRACTIC NEUROLOGY

THE NEURO CLINIC
Jon N. Chambers, DC
1663 Williams Highway
Grants Pass, OR 97527
Phone (541) 479-1289 Fax (888) 640-1719

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, be kept properly confidential. HIPAA gives the patient significant new rights to understand and control how health information is used. It also provides penalties for covered entities that misuse personal health information. We may use and disclose your medical records only for the following purposes:

- Treatment - Providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment- Obtaining reimbursement for services, confirming coverage, billing, and collection activities
- Health Care Operations - Conducting quality assessment and improvement activities, auditing, cost management analysis, and providing customer service.

We may also create and distribute de-identified health information by removing all individually identifiable Information.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services, which might be of interest to you.

Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights, which you can exercise by presenting a written request to our office.

- To request restrictions on certain uses and disclosures of protected health information. This includes disclosures to family members, other relatives, and personal friends, or other persons identified by you. We are not required to agree to requested restrictions. However, if we do agree to a restriction, we are obligated to abide by it, unless you agree in writing to remove it.
- To a reasonable request to receive confidential communications from us by alternative means or at alternative locations.
- To inspect and copy your protected health information.
- To amend your protected health information.
- To receive an accounting of disclosures of protected health information.
- To obtain a paper copy of this notice upon request.

This notice is updated and effective January 15, 2015 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provision effective for all protected health information that we maintain.

Should you feel your privacy protections have been violated, you may file a written complaint about violations of the provision of the notice or of the policies and procedures of our office, with this office or the Department of Health and Human Services, Office of Civil Rights (address below). We will not retaliate against you for filing a complaint.

For more information about HIPAA contact: The US Department Of Health and Human Services, Office of Civil Rights,
200 Independence Ave. SW Washington DC 20201 Phone 202 619-0257 or toll free (877) 696-677

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Effective Date 01/15/2015

Notice of Patient Privacy Health Insurance Portability and Accountability Act

The Neuro Clinic is dedicated to preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others to your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the top of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy. If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact The Neuro Clinic at (541) 479-1289. You may also send a written complaint to the US Department of Health and Human Services.

_____
Printed Name

_____ _____
Patient Signature Date

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DISCLOSURE OF FEES AND POLICIES

Welcome to The Neuro Clinic! We believe in a whole body approach to health care, and are determined to help evaluate and identify any health condition(s) you may have through examination and testing. Our goal is to help treat your medical condition(s) with various therapies by creating an individual treatment plan that will best serve each patient. Due to the nature of care in our clinic, we ask that you read, understand, and sign the following disclosures of fees and policies.

I understand that I am responsible for payment in full at the time of service. I understand that the initial examination fee is **$225.00**, with payment at time of service. Treatment and therapy prices are based upon time spent with the treating doctor and/or chiropractic assistants, HBOT technician, and massage therapist. I understand that time spent with the doctor is **$50.00 for up to 10 minutes, $75.00 for up to 15 minutes, and $100.00 for up to 20 minutes and so on**. Dependent upon the specific recommendations of the doctor, other fees for services received apply. A complete list of services received is available to me upon request in the form of a super-bill. All fees are subject to change without notice.

I understand that if I arrive late for an appointment, the doctor will see me for the remainder of my scheduled visit, if any. However, full price for the scheduled time will be charged.

I acknowledge that the policy of The Neuro Clinic is to schedule only one person to a specific time slot for the doctor, chiropractic assistant, hyperbaric chamber, or massage therapist. This allows the provider to devote their undivided attention to each individual. By honoring my time as well as the provider's, I can obtain the maximum benefit during my treatment.

In the event of a no-show, for any reason, I will be charged for the full appointment time.
By signing this form, I authorize The Neuro Clinic to fulfill this transaction.
If 24 hour cancellation notice is given, I will not be charged for the appointment.
Any nutritional supplements recommended to me, will be paid for at the time of service.

I fully understand and agree that health and motor vehicle accident policies are an arrangement between the carrier and myself. If prior authorization for billing such a plan has been approved but payment is not received, I accept full responsibility for the charges at the full rate, without discount for payment at time of service. I agree that if any expense is incurred in the collection of any monies due on my account, this amount will also become my responsibility. Furthermore, I understand that if I opt to pay at the time of service, The Neuro Clinic will prepare a super-bill and clinical Notes, if needed, to assist me in seeking reimbursement from my insurance carrier should I make this request.

I have read, understand, and agree to the terms above.

_____
Patients Printed Name

_____ _____
Signature of Patient or Guardian Date