Active Spine Center, LLC

2215 GARDEN STREET TITUSVILLE, FLORIDA 32796
Ph: (321) 268-2210 Fax: (321) 325-2100

OFFICE POLICIES AND PRIVACY STATEMENT

Our practice prioritizes top-notch patient care and service; please bear with any delays for your personalized attention. We're dedicated to offering superior Chiropractic and Rehabilitative care, tailored over time through scheduled visits based on your chiropractor's assessment. Adhering to your care plan, including visit frequency and duration, is crucial for optimal results. Our aim is to deliver professional, beneficial care to help you reach your health goals and resume a pain-free life swiftly.

Our office may occasionally access and share your Personal Health Information (PHI) for treatment, payment, healthcare operations, or as required by law. A detailed notice, available for your review, outlines your rights regarding the access and amendment of your PHI. It includes information about your identifiable health information, encompassing past, present, and future physical or mental health conditions, as well as any related healthcare services.

Appointment No-Show or Late Cancellation Policy:

At Active Spine Center, LLC, we strive for efficient and enjoyable visits. Our schedule is tight, and missed appointments hinder your treatment and deny others timely care. If you need to cancel or reschedule, please notify us promptly to reallocate your slot. Continual no-shows incur a $25 fee and disrupt both progress and our ability to serve others effectively. Please provide a 24-hour notice to avoid charges and help us maintain a smooth operation. Failing to cancel an appointment at least 24 hours in advance is considered a no-show or late cancellation, limiting access to care for others. Such instances will result in a $25 charge per missed appointment, which is the responsibility of the patient and not covered by insurance. This applies to all scheduled patients, including multiple bookings like siblings. Habitual breaches may lead to termination from our practice. Medicaid patients, while exempt from fees due to legalities, face dismissal for repeated infractions. We recognize emergencies may cause unavoidable absences.

_____Initial

To assist our patients, we handle filing claims with your primary insurance provider. Our staff will confirm your insurance coverage and inform you of your financial obligations promptly. Remember, health insurance agreements are between you, your employer, and the insurance company, making it your duty to ensure your insurer pays our office. While we may bill your insurance for services, all service charges ultimately fall to you, the patient. Should we encounter any issues in collecting from your insurance, we will notify you immediately.

If issues occur, you might have to reach out to your insurance company. Should we find that your insurer reimburses you directly instead of paying us, you'll need to settle the full cost of services when they're provided. We consistently work with insurance companies to help ensure your claims are paid accurately and promptly.

All insured patients are required to pay co-payments, deductibles, and any applicable percentages

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at each visit. If we do not participate with your insurance, we will still file claims on your behalf, but payment will be needed at the time of service.

Medicaid enrollees must have their eligibility verified monthly. If eligibility ends, you will be responsible for the cost of services received. For those injured at work, authorization from the Workman's Compensation Insurance is necessary before any appointments or treatments can be provided. Your employer will help you obtain this authorization.

Patient Agreement

I willingly agree to receive care, including necessary treatments and diagnostic procedures, to thoroughly assess my condition, under the guidance and supervision of the treating Chiropractor in this office.

Should my chiropractor need to provide my medical records, including patient histories, office notes, or questionnaires, to my insurance company for the purposes of medical payment review, I grant permission for this information to be shared.

I confirm that I have reviewed and understood the office policies related to my payment responsibilities for services received. I acknowledge that I sought clarification on any parts I did not understand from the office staff.

Furthermore, I have received and read the Notice of Privacy Practices for Active Spine Center, LLC, understanding its importance as mandated by HIPAA for maintaining privacy standards in healthcare settings.

PATIENTS WITHOUT INSURANCE ARE EXPECTED TO PAY IN FULL AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE.

PATIENT SIGNATURE:_____
PATIENT PRINTED NAME: _____
WITNESS SIGNATURE: _____
DATE:_____/_____/_____
The person or persons listed below may be given information concerning my Personal Health Information. This includes my treatment, payment, appointment times, insurance info and contact information.
Any Family member or friend of mine may be authorized to get my PHI ___Yes ___No
Only allow the following family member(s) or friend(s):
Relationship: _____
Relationship: _____
Relationship: _____

Patient Signature: _____ Date: _____

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