



Kentucky Sports Chiropractic
Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR 164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

- 1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Kentucky Sports Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing, this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 12106 Greenvalley Dr. Louisville, KY 40243. Attention: Practice Compliance Director.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

Two horizontal lines for entering restrictions.

I understand the foregoing provisions, and I wish to sign this Acknowledgement, authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Signature of patient or representative

Date

Patients Name

Date of Birth

Name of Personal Representative (if applicable)

Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

Accepted Denied Not Applicable Other (explain)

Signature of Authorized Practice Representative

Date

FINANCIAL POLICIES

Our policies for payments, insurance claims, and third party payment responsibilities are listed below. Please take a few minutes and read through and initial each one. If you have any questions, please feel free to ask.

PAYMENTS

Payment is expected at the time of service. We accept cash, checks, Mastercard and Visa.

INSURANCE

As a courtesy to you, we will process your insurance forms. We make every effort to provide sufficient information to you insurance carrier to obtain payment for your treatment. In some instances, insurance companies will deny or reduce payment despite our efforts to demonstrate the necessity for care. If full payment is not made by your insurance company, regardless or reason, you are responsible for the balance in full.

THIRD PARTY PAYMENT RESPONSIBILITIES

We are happy to provide treatment for accident victims who are involved in liability cases. We will make every effort to assist you in filing claims to a third party for the purposes of obtaining payment. We will usually extend credit in cases pertaining to personal injury claims, however all information must be given to our office immediately following the accident. You must provide us with any and all Attorney, Liability, Med pay and health insurance information. You must also sign an assignment of benefits form and a lien. In addition, your attorney must provide us with a "Letter of Guarantee".

In case of a minor, it is the responsibility of the accompanying parent or legal guardian to insure that payment is made in full.

RETURNED CHECK FEE

A \$35.00 service charge will be applied to all returned checks. Payment for any returned check must be paid in cash and include the \$35.00 fee.

Patient/Gurdian Signature

Date