

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*This form will be retained in your Chiropractic file.*

By my signature below I, \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices for Insight Chiropractic Inc PS (DBA Yelm Chiropractic).

In addition to my immediate family members, I hereby designate the following individual(s) to receive communications from Yelm Chiropractic and Wellness that may include health information about me.

\_\_\_\_\_

\_\_\_\_\_  
**Signature of patient (or personal representative)**

\_\_\_\_\_  
**Date**

If this acknowledgment is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or Disclosure of for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Chiropractic Examinations	\$35-\$250	Adjustment (5 regions)	\$75
New Patient Exam	\$60-\$245	Adjustment Extremity	\$40
X-Ray Studies (depending on views taken)	\$80-\$480	Traction	\$25
Basic Office Visit (Adjustment)	\$40-\$60	Therapeutic Exercise	\$45
Adjustment (3-4 regions)	\$60	Neuromuscular Re-Education	\$50
Adjustment (1-2 regions)	\$45	After Hours Emergency Calls	\$50

I have read the above codes and fee's and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments related to my care.

I understand that if a check of or debit is returned for insufficient funds, I will be charged a \$35.00 service charge. Any accounts over 30 days may be charged interest at rate of 12%. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court, and attorney fee's in the collection of my account.

I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case.

I have read and fully understand the above financial terms and prices.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date