





RAPP CHIROPRACTIC

**PATIENT FINANCIAL ACKNOWLEDGEMENT**

**CANCELLATION POLICY**

**NOTICE OF PRIVACY PRACTICES**

**Patient Financial Acknowledgement**

I certify that I, and/or my dependent(s), have health insurance coverage. I assign all insurance benefits directly payable to Rapp Chiropractic. I understand that I am financially responsible for all charges whether or not paid by insurance and guarantee payment of all charges incurred for treatment. I authorize the use of my signature on all insurance submissions. The doctor(s) may use my health care information and may disclose such information to the Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end one year from the date signed below. A photocopy of this assignment is considered as valid as the original.

I understand there is a \$10 per year charge for unpaid services. After one year of non-payment, services may be sent to collections and I will be responsible for all debt and collection charges.

**Cancellation Policy**

Rapp Chiropractic is dedicated to providing you with a great patient experience. We honor your time and appreciate your respect for our daily schedule to allow our staff to be on time for your appointment. We ask you arrive to your appointments 5 minutes early or on time in order to get the most out of your office visit.

- Please give as much notice as possible if you cannot make your appointment. Many clinics require 24-hour notice to cancel your appointment. We ask you give at least a 2-hour notice for same day cancellations so we can see other patients who may need our care. We encourage you to leave a voicemail at 651-423-2900 the day before if you know you need to cancel for the next day appointment.
- A no call/no show will result in a \$35 charge. This is defined as not calling to cancel or reschedule your appointment within 4 business hours of your appointment. The charge also applies if you are late to your appointment and we cannot accommodate the time change.

*We greatly appreciate your business and thank you for your cooperation with this policy.*

**Notice of Privacy Practices Acknowledgement and Consent**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This act gives you, the patient, the right to understand and control how your health information is used. If you would like a copy of our Notice of Privacy Practices, please ask our front desk staff and we will provide one for you. If you would like to read the notice in office, please ask our front desk staff and a laminated copy will be provided for you to read while in the office. By signing below, I give consent to Rapp Chiropractic to use or disclose my personal health information as noted in the Notice of Privacy Practices.

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<b>Patient Name (Please Print)</b>	<b>Signature of Patient/Guardian</b>	<b>Date</b>
<b>Relationship to Patient (if applicable) _____</b>		