ACTIVE CARE ATLANTA
6290 Abbotts Bridge Rd, Suite 204
Johns Creek, GA 30097
T: 770.559.4236 F: 770.559.4795
www.ActiveCareAtlanta.com

Payment Policies

(Please initial below)

_____ (initial) Our policy requires payment for all services at the time of visit. I understand that I am fully responsible for all charges.

_____ (initial) Our cancellation fee is $30.00 for a missed appointment without letting us know (via phone/voicemail/email) ***4 hrs before appointment time***. Appointment reminder service is complimentary but we urge you NOT to rely on it as technical issues can occur.

_____ (initial) As a courtesy, we verify insurance coverage for you. The verification we receive from your insurance plan is not a guarantee of benefits. In the event that my insurance company does not cover/pay the service, I acknowledge that I am responsible to pay the service.

_____ (initial) Patient balances 90 days old will be forwarded to a collection agency and a 23% fee will be applied.

_____ (initial) If payment is mailed directly to me from an insurance company, I will bring in the check within 2 weeks of receipt.

_____ (initial) There will be a $25.00 service charge on all returned checks.

Assignment of Benefit

---------- ***This section applies to patients wanting us to bill to insurance*** ----------

I direct and authorize **my insurance company to make payments *DIRECTLY* to ACTIVE CARE ATLANTA** for any and all benefits due as a result of the treatment.

I become fully financially responsible for any and all charges incurred in the course of treatment, including services not covered or paid by my insurance.

I hereby authorize **ACTIVE CARE ATLANTA** to: **(1)** release any information necessary to my insurance carriers and attorney to secure payment of benefits; **(2)** process insurance claims generated in the course of treatment; **(3)** issue a complaint to my insurance carriers or the Insurance Commissioner on my behalf if necessary.

A photocopy of this assignment is to be considered as valid as an original.

Guardian's Name _____ Signature _____ Date _____

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CONSENT TO TREATMENT

I give permission to all providers working for Active Care Atlanta to initiate care and provide treatment to my child. This authorization does not expire and is effective as long as my child is a patient.

Though rare, there are risks of complications associated with all health care procedures and treatments. These complications include but are not limited to: bruising, burns, muscle spasm, fractures, disc injuries and dislocations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Strokes have been the subject of tremendous disagreement. The occurrence of a stroke is exceedingly rare and is estimated to occur approximately once per 1 million to 5 million neck adjustments.

The Doctor will make every reasonable effort during the exam to screen for contraindications to care; however it's your responsibility to inform the Doctor if your child has a condition that would otherwise not come to the Doctor's attention.

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your **protected health information** (PHI). Our **Notice of Privacy Practices** details how we may use and disclose your PHI. You have the right to review our complete Notice which is located in the waiting room, front desk and our website.

By signing below you authorize our **use and disclosure of your PHI to third parties** for purposes related to treatment, payment, health care operations and those required by law. You also acknowledge that:

- **Active Care Atlanta** has a Notice of Privacy Practices you have had an opportunity to review.
- **Active Care Atlanta** may modify this Notice as needed at any time. If changes are made, they will be posted at our office.
- Certain situations may require the disclosure of patient PHI without patient authorization.
- Patient PHI may be used to contact patient as needed.
- Patient has the right to restrict the uses of his/her information.

The Patient may revoke this authorization at any time by submitting a written request to **Active Care Atlanta.** The request must include name, SS#, date of birth, address, a clear statement of intent to revoke this authorization and signature. This request is not effective until received and reviewed by **Active Care Atlanta**.

*By signing below, I've completely read the content above and I hereby give **my consent to the treatment** and acknowledge Active Care Atlanta's **Notice of Privacy Practices**.*

Patient / Guardian's Name _____ Signature _____ Date _____