Fasulo Chiropractic

Embrace Life Holistically

Patient's Name (Print):_____ Date of Birth: _____

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient Information except as stated In the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Fasulo Chiropractic to send/give my medical information as noted:

Leave a voice mall recording including my Personal Health Information on my home telephone: □ Yes □ No

Leave a voice mail recording including my Personal Health Information on my cell phone: □ Yes □ No

Leave a voice mail recording including my Personal Health Information on my business phone: □ Yes □ No

Leave a voicemail regarding only appointment confirmations on my home, cell phone or business phone number: □ Yes □ No

Use of electronic communication systems (I.e., fax, electronic messaging) to transmit prescription, treatment, disorder related Information, lab or other results: □ Yes □ No

Use of email to transmit treatment or disorder related Information which may include a diagnosis, lab or other result sent to me, even if the email is not encrypted (not protected over the internet.) □ Yes □ No

Permit the individual stated below (Personal Representative) to receive test results: □ Yes □ No

Speak to a family member of my choosing (Personal Representative as designated below) regarding my Personal Health Information; □ Yes □ No

Name of Designated Personal Representative (PRINT):_____

Relationship to Designated Personal Representative: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

On this date_____, I received, and reviewed Fasulo's Notice of Privacy Practices, which describes how my medical Information may be used and disclosed and explains how I can get access to this Information. I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

The authorizations made above will remain effective until such time as I notify Fasulo Chiropractic in writing, by certified mall, of requested changes.

_____ _____

Patient or Parent/Guardian Signature Today's Date

_____ _____

Patient Social Security Number Email Address

_____ _____

Patient Home Telephone Number Other Contact Number

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Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Confirmation of benefits is not a guarantee of payment and you, the patient, are responsible for any unpaid balance.
- I understand and agree that it is my responsibility to know if my insurance has any deductible, co- payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Patient Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____

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Patient Attendance Policy

Fasulo Chiropractic strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care. While we are sensitive to the fact that emergency may occur, and that life can sometimes get in the way of plans, cancellations, tardiness and absences reduce our ability to accommodate the scheduling needs of all our patients. As such, we request your full cooperation with the following company policy:

- If a patient is more than 20 minutes late for an appointment and fails to notify the office of the tardiness, treatment may be cancelled and/or a CANCELLATION or LATE FEE may be charged.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a cancellation fee of $25.00 will be charged for that appointment.
- Failure to show up for a scheduled appointment without providing the clinic with 24-hour advanced notification of your absence will result in a cancellation fee of $25.00 for that appointment.
- Patients that arrive late by 20 minutes or more, without prior notice, will be charged a $25.00 LATE FEE in addition to their services rendered that day.
- Repeated failure to comply with this policy will result in your appointments being scheduled based on availability, which will require you to call for an appointment on the day you seek to receive therapy.
- ALL FEES MUST BE PAID IN FULL PRIOR TO YOUR NEXT APPOINTMENT.

By signing below, I acknowledge that I have read the foregoing company policy and agree to its terms.

Patient Acknowledgement/Signature: _____ Date:_____

Parent/Guardian/Signature: _____Date:_____

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Fasulo Chiropractic Online Supplement Store through Fullscript

At Fasulo Chiropractic, we've made it easy for you to access professional grade supplements!

Why use Fullscript?

- Easily access your supplement recommendations and dosage instructions.
- Follow care plans and nutrition guides set by Dr. Fasulo to fit your lifestyle.
- Connect with Dr. Fasulo via email or phone with questions about your care plan.
- Purchase your products anywhere, anytime. Receive FREE shipping on orders of $50 or more.

Please check one (1) of the following options:

▢ YES, sign me up for Fullscript.

▢ NO, not right now.

Patient Name: _____

Email Address: _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____