

OUR MISSION STATEMENT

Our MISSION is to provide the best care possible to every patient, regardless of race, creed, religion, social background or sexual orientation which is accomplished by supporting our staff and providers in every way possible to allow them to practice efficiently and dedicate their time to the individual needs of the patient.

HEALTH CARE PRIVACY NOTICE

This office is committed to providing patients with quality health care services delivered with the same commitment and dedication as the rest of the health care industry. This office is committed to providing patients with quality health care services delivered with the same commitment and dedication as the rest of the health care industry. This office is committed to providing patients with quality health care services delivered with the same commitment and dedication as the rest of the health care industry.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice. This Facility is required by law to abide by the terms of this Health Care Privacy Notice. This Facility is required by law to abide by the terms of this Health Care Privacy Notice. This Facility is required by law to abide by the terms of this Health Care Privacy Notice.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI) about you, including demographic information, that may identify you as an individual. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI) about you, including demographic information, that may identify you as an individual. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI) about you, including demographic information, that may identify you as an individual.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed for health care delivery purposes. Your PHI may be used and/or disclosed for health care delivery purposes. Your PHI may be used and/or disclosed for health care delivery purposes.

The Privacy Rule allows you the right to review and receive copies of your health information. The Privacy Rule allows you the right to review and receive copies of your health information. The Privacy Rule allows you the right to review and receive copies of your health information. The Privacy Rule allows you the right to review and receive copies of your health information.

You may request to have an amendment placed in your record if you disagree with anything in your record. You may request to have an amendment placed in your record if you disagree with anything in your record. You may request to have an amendment placed in your record if you disagree with anything in your record.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably assign to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am insured. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably assign to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am insured.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party to release any information pertinent to said health care which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care.

Assignee agrees that this Facility & staff may deliver medical records, consultations, deposits, and other services. Assignee agrees that this Facility & staff may deliver medical records, consultations, deposits, and other services. Assignee agrees that this Facility & staff may deliver medical records, consultations, deposits, and other services.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, coAssignee agrees that this Facility & staff may deliver medical records to be paid in full in advance and authorizes this Facility to be paid in full in advance and authorizes adjuster, attorney or legal adjuster, attorney or legal service bureau to facilitate collections under the terms of this adjuster, attorney or legal attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness of attorney to endorse &/or sign my name on any for this facility are granted permission to wave all insurance provider contractual obligations, including any fee reduction or discounts

INSURANCE BENEFITS - CREDIT POLICIES - PAYMENT TERMS & CONDITION

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person. Your insurance company quote of benefits does not guarantee payment on any claims incurred by this or any facility. Benefits are determined when claims are processed and paid by the insurance carrier.

Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charge which you are responsible to pay.

Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.

Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.

All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below. I fully understand that if there is a 3rd party payer or responsible party that I have given permission for Frontier Integrated Health Center, Inc. and all providers for this facility to wave all Insurance provider contractual obligations, including any fee reduction and or provider discounts when concerning the full recovery of the fees for the provided services. Our office is not responsible for filing claims with your secondary health insurance.

A non-discriminatory Time of Service Discount is offered to anyone who pays for services the day they are rendered. The TOS is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.

A service charge is computed by a periodic rate of 11-1/2 % per month 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30.00 charge.

Patients are eligible for a maximum \$250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received my request of this document including the Health Care Privacy Notice, Informed Consent and fully understand and have had all of my questions answered. This document shall be considered as effective and valid as an original.

Print Name of Patient _____

X Signature (if minor, parent must sign)

Date
