WALLINGFORD FAMILY CHIROPRACTIC PLLC
2400 N 45th ST, SEATTLE, WA 98103
PHONE: 206.829.8669 FAX: 206.829.8982

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, was unable to do so, as documented below:
Date:
Initials:
Reason:

WALLINGFORD FAMILY CHIROPRACTIC PLLC
Payment Plans

To All New Patients

Please Initial Next to Your Method of Payment.

_____ **Cash Patient**: Payment is expected at the time services are rendered. We accept Visa, MasterCard, and American Express.

_____ **Insurance Patient**: You need to provide our office with your insurance information. We will bill your insurance as a courtesy to you; with the understanding that you are ultimately responsible for your account in our office. All co-pays are expected at the time of service.

_____ **Personal Injury Patient**: It is your responsibility to provide our office with any and all insurance information; including PIP, third party, health insurance, etc. We need all claim numbers and insured person's name, address, and phone numbers. You are responsible for payment to our office for any services rendered.

_____ **Labor & Industries Patient**: You are responsible for filling out Labor & Industries long form or the form for self insured L&I. You are also to have an accident report filed with your employer. If your claim is not accepted, you will be responsible for your account balance.

_____ _____

Patient Signature Date