# **NOTICE OF POLICIES**

# Welcome to our office! PLEASE READ

**CONFIDENTIALITY** Our office complies with HIPAA standards to protect the privacy of your personal health information. We do not release your PHI without your written consent unless required or permitted by law. We may contact you for reminders and announcements, as well as offers and health news.

If, in any way, you believe we have violated your privacy, please bring it to our attention.

**APPOINTMENTS POLICY** Thank you for understanding and respecting our valuable time.

CHANGES: We will do our best to accommodate time changes up to date of service.

<u>SAME DAY APPOINTMENTS</u>: Subject to availability. We welcome you to call if you are experiencing discomfort and usually can fit you into our busy schedule.

CANCELLATIONS: 48 hours in advance. SAME DAY cancellations are subject to \$25 charge.

NO SHOW:

First time- \$25

Second time- \$25 minimum charge. Third time- \$50 minimum charge.

Fourth time- We may be unable to schedule you in advance.

## FINANCIAL AGREEMENTS Copays and current charges are required at time of service.

We accept most insurance plans. <u>You are expected to know the general details of your coverage.</u>
Although we can estimate possible contracted charges, each policy, individual circumstances and contributing factors are unique.

Some insurance charges may be delayed as long as several months while we wait for your insurer to process claims. You are responsible for all charges not paid by insurance within 90 days of service including (but not limited to) New Patient Evaluation, Examination, Established Patient Re-evaluation, additional modalities such as Estim, Laser, Heat Therapy, K-taping, Manual Therapy, Treatment of Extremities or General Consultation.

**Past Due Invoices.** Payments are due upon receipt of invoice. Accounts PAST DUE over 90 days will be subject to monthly finance charges. In no case will those charges be less than \$15 and will be assessed monthly. Please call to resolve and settle any invoices. We can often help with discounts or terms.

UNINSURED TREATMENT	Our cash prices are affordable and competitive. If you are unable to afford
recommended treatment, a	ask our Practice Manager about an extended payment plan that fits your
budget.	

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Patient Signature	(print name)	Date

A. Notifier: THE RUSSELL CENTER 319 ELLIOTT ST BEVERLY MA	A 01	MA	_Y	ERL	BEVE	ST	IOTT	LL	) E	31	TER	CEN.	L	USSEL	THE	lotifier:	Α.
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B. Patient Name:

C. Identification Number: YEARS 2021-23

# (ABN)Advance Beneficiary Notice of Non-coverage

**NOTE:** If your insurance doesn't pay for **D.(below)**, you may have to pay.

Insurance or Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare, MassHealth and some commercial insurance policies may not pay forthe D.(below),.

D.	E. Reason May Not Pay:	F. Estimated Cost
EXTRASPINAL TREATMENT THERAPUTIC MODALITY NEW PATIENT EVALUATION RE-EVALUATION	NON-COVERED SERVICE NON-COVERED SERVICE NON-COVERED SERVICE NON-COVERED SERVICE	\$40 \$25 \$150 \$100

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D.\_.(above). Note: If you choose Option 1 or 2, we may help you to use any other insurance you have, but Medicare or your insurer cannot require us to do this.

G. OPTIONS: Check only one bo	x. We cannot choose a box foryou.
Insurance billed for an official decision on part understand that if my insurer doesn't pay, any payments I made to you, less co-pays of the state o	
may ask to be paid now as I am responsible	listed above, but do not bill Medicare or my insurer. You e for payment. I cannot appeal if insurer is not billed.
OPTION 3. I don't want the D responsible for payment, and I cannot appe	listed above. I understand with this choice I am <b>not</b> eal to my insurer.

### H. Additional Information:

This notice gives our opinion, not an official decision. If you have other questions on this notice or billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048), or the phone number provided on your commercial insurance card.

Sian	ing below means that	t you have received and under	stand this notice.	You may	request a copy.
	<b>A</b> : 1		I Dete		

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CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



The Russell Center for Chiropractic & Sports Medicine
319 Elliot Street, Beverly, MA 01915 | Office Phone: (978) 927-2607 | Fax: (978) 927-2463

Name:	D.O.B.;	Today's Dat	e:
Have you ever been diagnosed with any of the following conditions? (Check if yes)	Please use the following		
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Arteriosclerosis	This and recales	in = inditioness	S = Stabbing
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Back Pain		<b>k</b>	$\bigcirc$
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Cramps			
Depression	/ / //	$A \setminus A$	<i>n</i> \
Diabetes (type:)			
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Hemorrhoids	1	1	1 /
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Irregular Heart Beat	<b>! !</b>		
Irregular Cycle	1 1	1	
Kidney Infection Kidney Stones	\ \frac{1}{2}	/	
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Loss of balance	113		<u>/</u>
Loss of smell	-		
Loss of taste Neck Pain or Stiffness			
Nervousness			
Nosebleeds			
Pacemaker			
Polio			
Poor Posture Prostate Trouble			
Sciatica			
Shortness of Breath			
Sinus Infection			And the state of t
Sleep Problems or Insomnia Spinal Curvatures			
Stroke			
Swelling of Ankles			
Swollen Joints		Y	
Tuberculosis		\	
Ulcers	2 3 3		
Varicose Veins	/ 3		
Venereal Disease Other:			



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