NOTICE OF PRIVACY PRACTICES, PAYMENT RESPONSIBILITY AND CANCELLATION POLICY

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our commitment is to serve you, our patient, with professionalism and care, as well as being sure at all times to protect the privacy and security of all Protected Health information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or business associates. The following are examples of instances where information may be shared:

- Insurance processing and/or insurance company requests;
- Referrals to specialists requiring shared information;
- Acquiring lab analysis during treatment.

We are committed to obeying all Federal, state and local laws, as well as regulations regarding Privacy Practices. If any other uses of disclosures than the ones listed above are needed, information will be released with the written authorization from you, the individual in question. You may revoke this written authorization at any time, as provided by law.

If you have any questions or comments regarding your Protected Health Information, please contact our office. _____ ***Initial here***

For all types of payments, cash, check, charge, health insurance, Medicare, auto insurance and workers compensation, please read and sign below.

If your services are covered by insurance, complete the appropriate forms. If someone other than you pays for your treatment, complete the *Guarantor* section of the medical insurance page.

I understand I am responsible for payment of all treatment, supplements and supplies provided by Jan Corwin, DC, LLC. I also agree to make payment in fill at the time of the session unless other arrangements are made in advance. In any event, I will be responsible for all costs of collections, including reasonable attorney fees. If I fail to make timely payments, I understand an interest rate of 1.5% per month will be charged on all balances unpaid sixty (60) days for the billing date. ______ ***Initial here***

Allow 24 hours notice for changing or cancelling your appointment. There will be a $35 fee assessed for any *cancellation* or *not show* less than 24 hours in advance of your scheduled appointment. _____ ***Initial here***

I have read and understand the above Notice of Privacy Practices, Payment Responsibility and Cancellation Policy.

Signature: ____ Date:_____/_____/_____
Patient or Legal Guardian

Jan Corwin, DC 316 NE 28th Avenue, Portland, OR 97232 503-230-0812