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Financial Policy

Private Payments:
Payments are expected at the time of service. We accept cash, checks, Visa, MasterCard, Discover, and American Express. If there is a problem with payment, please let us know immediately. We do not want financial problems to interfere with your care.

Insurance:
Please refer to your insurance company's agreement for chiropractic care benefits. We will gladly file any necessary insurance forms and claims on your behalf with insurance carriers with whom we are contracted as in-network providers. We are unable to file claims for any insurance carriers for which we are not in-network. Please note that your insurance is a contract between you and/or your employer and the insurance company, and that you are ultimately responsible for all referrals, co-payments, and deductibles where applicable. Payment is due at the time that services are rendered, and the patient is responsible for any unpaid balances.

Personal Injury:
We will accept Med-Pay (medical coverage on your auto insurance policy) and Third-Party cases. You will need to provide our office with a claim number, the adjuster's phone number, and the automobile insurance company's billing address. Med-pay will cover your doctor's bill regardless of who was at fault. We will bill your auto-insurance company for prompt and direct payment for your care, up to your policy limits. If this is a Third-Party claim, we would prefer to have an attorney's Letter of Protection. Payment in full is expected upon case settlement. **The patient is ultimately responsible for any and all services rendered.**

Missed Appointments:
Please give our office a minimum of 24 hours ' notice for any cancellation or rescheduling of an appointment. Special exceptions and emergencies will be taken into consideration. Our office books appointments several weeks in advance and has a long waiting list of patients hoping to be seen. Please be courteous to your fellow patients and help us serve you better by keeping your scheduled appointments. **Without 24 hours' notice, there will be a $30 + tax missed-appointment fee (not billable to insurance) for most visits, and a $45 + tax fee for a missed 90-minute massage.**

Check Return Policy:
If, for any reason, this unfortunate situation arises, the patient will be charged a $25.00 fee per occurrence.

I, _____ understand and accept the above stipulations and acknowledge that I am financially responsible for the services rendered. I understand and agree that my insurance coverage is a contract between the insurance company and me. I also understand that if I suspend or terminate my care and treatment, any balance for professional services rendered to me will be immediately due and payable. I also understand that any account 30 days past due will be subject to interest at 1.5% per month (18% annual) retroactively. I will be financially responsible for charges if a collection agency is utilized.

Responsible Party Signature: _____ **Date:** _____

Witness (office personnel): _____

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Authorization Form

Authorization is hereby granted to Dr. Paul Hordes, DC, Dr. Amanda K. Lopez, DC, and Dr. David R. Bixel to release any information that is acquired in the course of my examination and treatments to any insurance company, attorney, or adjuster. I, _____ authorize and assign direct payment to Active Chiropractic Spine & Joint Center, LLC and Dr. Paul Hordes, DC of any sum I now or hereafter owe this office by my attorney out of the proceeds of any settlement of my case and/or by an insurance company obligated to reimburse me for the charges of these services.

I clearly understand and agree that health and accidental insurance policies are an arrangement between the insurance carrier and myself. As healthcare providers, our relationship is with you, not your insurance company. Assisting in the filing of claims is a courtesy we extend to our patients. I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment, and I agree to pay all billing on a timely basis. I also understand that any amount authorized to be paid directly to this office will be applied to any outstanding balance that I owe.

I understand that in personal injury cases, payment may be deferred until settlement, with the total due in full at settlement, providing that no other insurance is involved and if an attorney approved by this office is representing me.

I further understand that if I suspend or terminate my treatment in this office, or if I discharge my attorney or he/she discontinues my representation, any fees for professional services rendered to me will be **immediately due and payable**. I also agree to pay any and all reasonable legal fees and court costs incurred on the collection of this account.

Limited Power of Attorney: I hereby grant to the physician/facility named above the power to endorse upon any checks, drafts, or other negotiable instrument representing a payment from any insurance company or attorney's office for payment of treatment and health care rendered by the physician/facility. I agree that any insurance payments representing any amount in excess of charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

Patient Signature: _____ **Minor's Name:** _____ **Date:** _____

Witness: _____ **Parent/Guardian:** _____

Permissions and Contact Information

I, _____ agree to receive text messages and calls to the numbers listed on the New Patient Intake Paperwork forms for appointment reminders and billing information. Active Chiropractic Spine and Joint Center may also leave messages at the same listed numbers for appointments and billing information.

Signature: _____ Date: _____

Active Chiropractic Spine and Joint Center may discuss my information, including scheduling of appointments and billing information with the following person/people:

1)_____ _____ _____
Name Phone # Relationship to patient

2)_____ _____ _____
Name Phone # Relationship to patient

Signature: _____ Date: _____

If Applicable: I give permission for my minor child, _____ who is under the age of 18, to be treated by Active Chiropractic Spine and Joint Center in my absence. Furthermore, I give the following person/people permission to accompany my child to their appointment and to relay pertinent information to me regarding my child's treatment and care during the following time period:

From: _____ To: _____ _____ _____
Signature Date

1)_____ _____ _____
Name Phone # Relationship to patient

2)_____ _____ _____
Name Phone # Relationship to patient

If Applicable: I give permission to my minor child, _____, who is over the age of 15, to attend and receive treatment at Active Chiropractic Spine and Joint Center without my being present during the following time period:

From: _____ To: _____

Signature: _____ Date: _____

Notice of Informed Consent

Every type of healthcare is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic care before consenting to treatment.

Subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of their normal alignment, or is restricted in their motion. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A Subluxation has also been described as an incomplete dislocation of a joint, and as such, it is not treated with drugs or surgery. Chiropractors treat vertebral Subluxation with spinal manipulation, (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments, and create normal joint movement. Frequently, adjustments create a popping or clicking sensation in the area being treated.

In our office, we use highly trained staff to assist the doctor with portions of your consultation, examination, x-rays, physiotherapy, traction, massage, exercise instruction, and other treatments. Occasionally, when your doctor is not available, another clinic doctor will be available to treat you in their place.

Stroke: There is a remote chance of a rare type of stroke associated with manipulation of the cervical spine. We take particular care to avoid this type of manipulation.

Disc Herniation: Disc herniations that create pressure on the spinal nerves or the spinal cord in the neck or low back are treated successfully by chiropractors with adjustments and spinal decompression. Occasionally these treatments can irritate this problem. To help prevent this, patients are put through specific tests and procedures during the examination to see if the treatment might aggravate disc symptoms. Complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely, chiropractic adjustments, traction, massage, and other treatments may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution with no long-term effects on the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found attached to the thoracic spine in the middle back. They extend from your back to the front of the chest. Rarely, a chiropractic adjustment may break a rib. This is referred to as a fracture. While this can occur in any patient, this usually occurs only in those patients with weakened bones from conditions such as osteoporosis, prolonged steroid use, or other bone-weakening diseases. Let your doctor know if any of these apply to you. We adjust all patients carefully, especially those with bone-weakening conditions. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of electricity, light/laser therapy, heat, and ice in the office, and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely, electricity, light/laser therapy, heat, or ice can irritate the skin. The result is a temporary increase in skin pain and possibly some blistering or burning. These problems also occur so rarely that there are no available statistics to quantify their probability. If you ever feel any discomfort during treatment, immediately inform a staff member to prevent any unnecessary injury.

Soreness: It is not uncommon for spinal adjustments, distraction, massage, exercise, and other therapies to result in a temporary increase in soreness to the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell the doctor or a staff member about it.

Other Problems: There may be other problems or complications that arise from chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for all symptoms, diseases, or conditions as a result of treatment at this facility. We will always give you the best care we can deliver and if the results are not acceptable, we will gladly discuss other types of treatment options, or refer you to another healthcare provider for alternative types of treatment.

If you have any questions about the above information, please ask your doctor to explain them in more detail. When you have a full understanding of this material, please sign and date below.

Authorize to Treat: I, the undersigned, hereby authorize Dr. Paul Hordes, DC, Dr. Amanda K. Lopez, DC, Dr. David R. Bixel, DC, and whomever he or she designates to administer such chiropractic, physical therapy, massage therapy, and/or therapeutic treatment or medical procedures as they consider therapeutically necessary on the basis of findings during the set course of treatment.

Patient Signature: _____ **Date:**_____

Patient Name: _____ **Witness:**_____

Consent for Treatment of a Minor: I, the undersigned, hereby authorize Dr. Paul Hordes, DC, Dr. Amanda K. Lopez, DC, Dr. David R. Bixel, DC, and whomever he or she designates to administer such chiropractic, physical therapy, massage therapy, and/or therapeutic treatment or medical procedures as they consider therapeutically necessary on the basis of findings during the set course of treatment to

Minor Child's Name: _____ **Parent/Legal Guardian:**_____

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Massage Consent

I understand that the massage I receive is for the purpose of stress reduction and relief of muscular tension, spasm, or pain, and to increase circulation. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods used, including cupping, can be adjusted to my comfort level. I understand that massage therapists do not diagnose illness or disease, nor do they perform spinal manipulations or prescribe any medical treatments, and nothing said or done during the session should be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis, and I should see a healthcare provider for those services. Because massage should not be performed under some circumstances, I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist from any liability if I fail to do so.

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. I acknowledge that I am aware of the risks involved in receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

_____ _____
Patient Signature Date

_____
Printed Name

_____ _____
Therapist Signature Date

_____
Printed Name

Active Chiropractic Dry Needling Consent

Potential risk of Physical therapies includes exacerbation or lack of progress in the following areas: Symptoms (pain, numbness/ tingling), swelling, range of motion, strength, and/or function. Benefits include improvements in the treatment areas. Other specific risks and benefits vary by condition, and you will be provided information and every opportunity to ask questions. With any service offered, you maintain the right to decline a treatment or intervention at any time.

Dry Needling (DN)
DN is a technique that involves the insertion of needles similar to acupuncture needles (without medication) to promote healing within the body. Dry Needling works by changing the way your body senses pain (neurological effects), and by helping the body heal itself. There are additional electrical and chemical changes associated with dry needling therapy which assist in the healing process. It is important to understand that dry needling may act as just one part of your overall rehabilitative treatment. Treatment techniques are based on concepts of modern medicine and are not to be considered acupuncture or meridian therapy. Risk of injury and/or potential complications could result from DN if proper precautions are not observed. If you are being treated in the shoulder, neck, back, or chest area there is an additional risk that involves your lung. If the lung itself is punctured, you may develop a condition called Pneumothorax, or a collapsed lung. This is a rare but serious problem, and you should go directly to the hospital ER department without panicking if it occurs. The symptoms of this event include shortness of breath, a bluish tinge to your lips, and an inability to "catch your breath". In general, there is very little risk associated with this technique if performed properly by a trained practitioner.

- You may feel sore immediately after treatment in the area of the body you were treated. This is normal, but does not always occur. It can also take a few hours, or until the next day before you feel soreness. The soreness may vary depending on the area of the body that was treated. It also varies from person to person, but typically it feels like you had an intense workout at the gym. Soreness typically lasts 24-48 hours. If soreness continues beyond this, please contact our office.
- It is common to have bruising after treatment, or even a small drop of blood may surface on the skin after treatment. Some areas are more likely than others to develop this. Some common areas are the shoulders, base of the neck, head, face, arms, and legs. Large areas of bruising rarely occur, but can. Use ice to help decrease the bruising, and if you feel concerned, please contact our office.
- It is common to feel tired, nauseous, emotional, giggly or "loopy", and/or somewhat "out of it" after treatment. This is a normal response that can last up to an hour or two after treatment. If this lasts beyond one day, contact our office as a precaution.
- There are times when treatment may make your symptoms worse. This can be a normal response. If this continues past the 24–48-hour window, keep note of it, as this is helpful information, and your provider will then adjust your treatment plan based on your report, if needed. This does not mean DN cannot help your condition.

Complications that could result from Dry Needling:
Bleeding / Bruising / Muscle soreness / Muscle tightness / Paresthesia / Joint stiffness / Pain / Swelling / Nausea / Anxiety / Dizziness / Referral of pain of muscle twitch **/** Local infection / Nerve injury

Patient Signature: _____ Date:_____

Printed Name: _____ Practitioner Signature: _____

Notice of Patient Privacy Policy

I, _____, was given a written copy of the Active Chiropractic Spine & Joint Center, LLC Notice of Patient Privacy Policy.

_____ _____

Patient Signature Date

_____

Printed Name

Active Chiropractic Spine & Joint Center, LLC

NOTICE OF PATIENT PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how Active Chiropractic Spine & Joint Center, LLC may use and disclose your health information and how you can access this information. This Notice explains how we use and share your health information and describes your rights and our legal duties under federal and state privacy laws.

Who This Notice Applies To

This Notice of Privacy Practices applies to our chiropractic practice and all related services we provide, including those performed by our support staff and business associates who help deliver or manage your care. We follow the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Notice applies to you as a patient of our practice and to any services we provide in connection with your care.

If you have any questions about this Notice, please contact our Privacy Officer or any staff member in our office.
Privacy Officer: *Paul Hordes*

Practice Name: *Active Chiropractic Spine & Joint Center, LLC*
Address: *7007 Wyoming Blvd. NE A-3 Albuquerque, NM 87109*
Phone: 505-822-5001

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

We may change the terms of this Notice from time to time. When we make a significant change, we will post the revised version in our office and, if applicable, on our website. You may obtain the current version at any time by contacting our Privacy Officer or asking at the front desk. You may contact our Privacy Officer in person at our office, by mail at the address above, or by phone.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information about you that may identify you and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or payment for that care.

USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION

Federal law (HIPAA) permits us to use and disclose your protected health information for treatment, payment, and health care operations without a separate written authorization, as described in this Notice.

Treatment

We may use or disclose your PHI to provide, coordinate, or manage your health care and related services. This includes sharing information with other health care providers involved in your care.

Payment

We may use or disclose your PHI to obtain payment for services provided to you. This may include billing insurance companies, determining eligibility or coverage, utilization review, and related activities.

Health Care Operations

We may use or disclose your PHI to support the business operations of this practice, including quality assessment, employee training, internal audits, and administrative activities.

We may use sign-in sheets or call you by name in the waiting area as part of our normal operations, in a manner consistent with applicable privacy requirements.

BUSINESS ASSOCIATES

We may share your PHI with third-party "business associates" who perform services for us (such as billing, IT support, or transcription). These entities are required by contract to protect the privacy and security of your PHI.

To the extent applicable, we will require, through our agreements with that business associate, that they protect those records in accordance with applicable Part 2 confidentiality requirements.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. These include:

- Disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes
- Disclosures that constitute a sale of PHI
- Other uses and disclosures not described in this Notice

Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2

Certain records related to Substance Use Disorder (SUD), if present in your record, receive additional confidentiality protections under federal law (42 C.F.R. Part 2).

Our primary services are chiropractic care. We are not a substance use disorder (SUD) treatment program as defined by federal law. However, we may receive or maintain information related to SUD treatment if you or another provider shares that information with us.

If our office maintains such information—such as information received from other providers, hospitals, or patient disclosures—those records generally will not be used or disclosed without your specific written authorization, except as otherwise permitted or required by federal law.

A standard authorization to release medical information may not be sufficient to permit disclosure of SUD-protected records. When required by law, we will obtain an authorization that specifically covers SUD information and complies with 42 C.F.R. Part 2. You may revoke your authorization for us to disclose SUD-protected records at any time by submitting a written request to our Privacy Officer. Revocation will not affect disclosures already made in reliance on your prior authorization.

Most patients seen in our chiropractic practice will not have records covered by these special rules. This section applies only if we receive or maintain information from an SUD treatment program.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may use or disclose your PHI without your authorization in the following situations:

Public Health & Safety - For public health activities, reporting communicable diseases, preventing serious threats to health or safety, and as required by law.

Health Oversight - To health oversight agencies for audits, investigations, inspections, and compliance activities.

Abuse, Neglect, or Domestic Violence - As required or permitted by law to appropriate authorities.

Workers' Compensation - As authorized to comply with workers' compensation laws.

Required by Law - When disclosure is required by federal, state, or local law.

Important Note About SUD Records: Some disclosures described in this section do not apply to records protected by 42 C.F.R. Part 2. Please see the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for information about how we handle SUD-protected records.

LEGAL PROCEEDINGS & LAW ENFORCEMENT

We may disclose PHI in response to a valid court order, subpoena, discovery request, or other lawful process as permitted by law.

Important: Records protected under federal Substance Use Disorder confidentiality regulations (42 C.F.R. Part 2), if applicable, may only be disclosed pursuant to a court order that specifically authorizes such disclosure or as otherwise permitted by federal law. A subpoena or legal request alone may not be sufficient for disclosure of SUD-protected information.

If we maintain records protected by 42 C.F.R. Part 2, those records are subject to stricter rules than other PHI. Please refer to the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for details.

YOUR RIGHTS

You have the right to:

- **Inspect and Copy** – You may inspect and obtain a copy of your PHI, subject to certain legal exceptions and reasonable, cost-based fees.
- **Request Restrictions** – You may request limits on certain uses or disclosures of your PHI; however, we are not required to agree to all requests.
- **Confidential Communications** – You may request that we communicate with you by alternative means or at alternative locations.
- **Amend** – You may request that we amend your PHI if you believe it is incorrect or incomplete.
- **Accounting of Disclosures** – You may request an accounting of certain disclosures of your PHI as defined by law.
- **Breach Notification** – If there is a breach of your unsecured PHI, we will notify you as required by applicable law.
- **Paper Copy** – You may request a paper copy of this Notice at any time.

To exercise any of these rights, please submit a written request to our Privacy Officer.

SPECIAL RIGHTS REGARDING SUD RECORDS

If our office maintains records protected under 42 C.F.R. Part 2, you have additional rights related to those records. Disclosure of such information generally requires your written authorization, and you may revoke that authorization at any time. Revocation will not apply to disclosures already made in reliance on your authorization.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services by visiting www.hhs.gov/hipaa or calling 1-800-368-1019.

To file a complaint with our office, please contact the Privacy Officer at the address or phone number listed above. You will not be penalized or retaliated against for filing a complaint.

EFFECTIVE DATE

This Notice of Privacy Practices is effective as of: February 16, 2026
