Welcome to our office! Let us take a moment to introduce ourselves.

Dr Shawn Lee was born in Atlanta and raised in Texas. After graduating from BYU, he received his Doctorate in Chiropractic from Texas Chiropractic College. Dr Lee and his wife Wendy, a Bel Air native, opened the office in 2006. Dr Lee first gained interest in Chiropractic from his parents but it was his drive to help Wendy recover from an old sports injury that really inspired him. Dr Lee has had extensive additional training in the treatment of the TMJ; dry needling; and rehab of non-spinal injuries and disorders. Dr. Lee is a dance injury specialist. In addition, Dr Lee is also a NRCME examiner providing DOT exams to commercial drivers. He his also dance dad and doctor to their 3 daughters while Wendy is the costume mom.

Eric Smith LAc. Born and raised in Harford County, Eric became interested in Acupuncture while studying martial arts. Eric has trained in Tae Kwon Do and Chinese Kung Fu and now teaches Tai Chi. He studied Chinese language and Asian art before receiving his Masters from the Traditional Acupuncture Institute. He practices both Traditional Chinese Medicine (TCM) and Traditional Acupuncture (5-Element) styles of acupuncture. He enjoys reading and meditation. Eric and his girlfriend live in Bel Air with *her* cats.

Lisa Gilliland, LMT was born and raised in Baltimore County. Lisa first started out in child care wanting to become a teacher because she really enjoyed helping children, but that became very stressful with her husband being off and on deployed as active duty army and raising 4 boys. She decided she still wanted to help people, so she got into Massage Therapy and figured that is a much more relaxing job. Lisa has been a Massage Therapist for 11 years now. She certified in Swedish, deep tissue, prenatal, and hot stone. Lisa currently resides in Joppatowne. She is very busy with four boys, a husband and a cat at home. She is either on the soccer or baseball field.

Dr. Joseph Hickey, Chiropractor
Dr. Hickey is a 2017 graduate of New York Chiropractic College and is licensed to practice in the state of Maryland with full physical therapy privileges. Dr. Hickey holds certifications in Activator Technique and ConnectX therapy. During the last year of his education, he completed clinical hours working at different clinics around the area of Seneca Falls, New York. While working he furthered his diagnostic skills and chiropractic techniques. When he is not working, Dr. Hickey enjoys spending time with friends and family; some of his hobbies include running, hiking, cycling, skiing, golfing and video games.

Susquehanna
Spine & Rehab
Chiropractic, Physical Therapy & Massage

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Shawn R. Lee D.C.
2105 Laurel Bush Rd #103 ● Bel Air, MD 21015
Phone: 443-512-0025 ● Fax: 443-512-8844 ● www.susquespine.com

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Practice Name: Shawn R. Lee, D.C. The effective date of this Notice of Information Practices is 02/01/06.

Disclosure of Protected Health Information

Protecting the privacy of your personal health information (PHI) is important to us. This acknowledgement is a summary of the full Notice of Privacy Practices which outlines in detail how information about you may be used and disclosed and how you can get access to this information. The full policy refers to guidelines outlined in federal mandates of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Omnibus and is available upon request and posted on our Practice's website.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities and for treatment, payment, or practice operations. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may access copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain an accounting of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice via email, phone and or text.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

In addition, I hereby authorize the release of information to personal acquaintances named below (and relationship) or fill in none.

1) _____ Relationship: _____

2) _____ Relationship: _____

I acknowledge that I have access to the full Notice of Privacy Practices for protected health information. I hereby grant consent for Susquehanna Spine & Rehab to release any information necessary for my course of treatment, payment or healthcare operations.

_____

printed Name Signature

Informed Consent for Examination and Treatment

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I (we) hereby consent to the performance of examination and treatment on me or on _____ by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon fads known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____ ☐ I am pregnant

_____

Patient's Name (Print) Patient's Signature

_____

Relationship or authority if not signed by patient Date

OFFICE FINANCIAL POLICY

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If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time (without prior arrangements) or care may be terminated. Our payment plans make care an affordable part of your family budget.

If You Have Insurance:

- **Billing**: Your insurance provider will be billed, and we will share information with them as needed to get the bills paid. Please make sure your benefits are assigned to pay this office directly.
- **Patient's Financial Responsibility**: Many insurance plans have deductibles, co-insurance and/or co-payments and payments are expected at the time of service or by an authorized payment plan. Your balance may not exceed $100 (without prior arrangements) or care may be terminated. Our payment plans make care an affordable part of your family budget. There are some plans where there is no patient responsibly.
- **PIP/ WC/ VA:** Most often there is no patient responsibility assigned by the insurance provider.
- **Insurance Information**: You are considered a cash patient until you submit your completed insurance forms to this office, and we qualify and accept your insurance coverage. It is YOUR responsibility to provide this office with the proper information to submit claims to the insurance provider. Including ID or claim numbers, insurance cards and/or adjuster names and phone numbers. You must provide this for all companies you wish for claims to be sent.
- **Insurance Verification**: As a courtesy we will do our very best to verify your insurance coverage and will bill your insurance company in a timely manner. We will provide this information to you and estimate to the best of our knowledge your patient responsibility. Due to the variance from one insurance policy to another these amounts are estimates and final patient responsibility will be determined by each insurance carrier.
- **Referral/ Authorizations**: Some insurance companies will require referrals or authorizations you will be responsible for obtaining referrals. You will need to present a completed referral at the time of your appointment. Our office will submit for authorizations. In the event that you are seen without the proper referral or authorizations as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us.
- Some insurance companies will send questionnaires and hold all payments until paperwork is completed. Please provide this office with a copy of this paperwork. Failure to submit requested questionnaire to the insurance carrier will result in denial of claims and all balances will become patient's responsibility.
- Our fees are considered usual, customary and reasonable by most companies, and therefore, usually are covered up to the maximum allowance determined by each carrier. You will have access to statements from your insurance provider; sometimes insurance carriers can take up to 60 -90 days to process. This office will rebill and submit appeals on your behalf and do everything in our power to ensure claims are paid. If the claim is denied by your insurance company for any reason, you accept responsibility for payment in full of any outstanding balance.
- If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

I understand that all fees incurred by me including but not limited to co-pays, deductibles, fees for service, DME or other are ultimately my responsibility and agree to pay in full regardless of claims made, denials or refusals; and hereby waive all statutes and/or limitations restricting the collection of said fees; and agree to pay any and all attorney's and/or agency fees regarding the collection of any un-paid balances. For your convenience you may retain your credit card number on file with us.

_____

Patient's Name (Print) Patient's Signature

_____

Guardian signature Relationship if not signed by patient Date

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Authorization and Assignment

I hereby authorize direct payment and assign benefits to Shawn R. Lee, DC any and all insurance, personal injury and/or other benefits payable to the patient, me or other.

I authorize direct payment to you of any sum I now or hereafter owe you by an attorney or out of proceeds of any settlement of my case.

If my current policy prohibits direct payment to the doctor or otherwise remits and/or sends any payments to me, the patient, an attorney and/or other I will immediately assign and forward such payments to Shawn R. Lee, DC.

In the event of refusal of payment by any of the above, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies' proceeds, I personally owe and agree to pay.

I hereby waive the statute of limitations on collections in the State of Maryland.

I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies are paid in full.

Any balance after thirty days will accrue interest at one and one half percent per thirty day period. If the balance were to be referred to a collection attorney, I will be responsible for all attorneys' fees, court costs and all other expenses occurred while in attempt to collect.

I understand that all charges incurred during the course of my care are my responsibility and agree to pay all said fees in full if not otherwise assigned by my insurance company, or if payment is denied or refused.

Signature_____

Name_____

Date_____

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