Susquehanna Spine & Rehab
Chiropractic, Physical Therapy & Massage

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 inspired him. Dr. Lee has 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. Dr. Lee is also an NRCME examiner providing DOT exams to commercial drivers. He is also a 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.

Lisa Gilliland, LMT was born and raised in Baltimore County. Lisa first started her career in child care, wanting to become a teacher because she enjoyed helping children. As a military wife and mom to four boys, child care and teaching became too stressful. She decided she still wanted to help people; she went into Massage Therapy seeking a more relaxing career. Lisa has been a Massage Therapist since 2006 and is 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. Maria Leone, Chiropractor
Dr. Maria Leone was born and raised in Rhode Island. She played D1 Rugby and graduated from The University of Rhode Island with her Bachelor's in Kinesiology. As a college athlete, Dr. Leone is passionate about athletes playing hard, increasing performance, and preventing injuries. Dr. Leone is graduated from New York Chiropractic College. She is excited to help her patients relieve pain, rehabilitate, increase movement, and live happy active lives. When she is not treating patients, you will find her having fun exploring her surroundings, playing sports, and working out.

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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Acknowledgment Receipt of Privacy Practices

Practice Name: Shawn R. Lee, D.C. The effective date of this Notice of Information Practices is 04/05/2021.

Disclosure of Protected Health Information

Protecting the privacy of your personal health information (PHI) is important to us. This acknowledgment 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 the Health Information Portability and Accountability Act of 1996 (HIPAA) and Omnibus. It is available upon request and can be found 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, and law enforcement activities. You are giving your consent for the release of information for treatment, payment, and healthcare operations. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure.

A patient (or representative) may submit a records request via phone, text, or email. Per the 21St Century Cures Act and Information Blocking regulations these records will be made available to you as soon as possible and free of charge. Records may be released to other persons or entities' however you must provide a signed authorization. Our practice has the right to accept, delay or deny your request according to Information Blocking Exceptions. You may request changes to your records. We maintain a history of protected health information disclosures that is accessible to you.

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

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 visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I acknowledge that I have access to the Notice of Privacy Practices for protected health information. I hereby authorize Shawn R. Lee DC to release any information necessary for my course of treatment and payment of my treatment.

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

1) _____ Relationship: _____

2) _____ Relationship: _____

_____

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 others.

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 a 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 that occurred while in an 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.

_____

Patient's Name (Print) Patient's Signature

_____ Guardian signature Relationship if not signed by patient Date

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OFFICE FINANCIAL POLICY

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

If You Have Insurance:

- **Billing**: Your insurance carrier will be billed, and we will share information with them as needed.
- **Patient's Financial Responsibility**: Many insurance plans require patient payments for 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. There are some plans where there is no patient responsibility.
- **PIP/ WC/ VA:** Most often there is no patient responsibility assigned by the insurance provider. It is your responsibility to ensure that these cases and claims are up to date.
- **Insurance Information**: You are considered a self-pay 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 accurate 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 an 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 need to present a completed referral from your PCP at the time of your appointment. Our office will submit for authorizations. If 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.
- You MUST inform the office if you have had visits to another chiropractic OR PT office during this benefit year.
- Some insurance companies will send questionnaires and hold all payments until the paperwork is completed. Please provide this office with a copy of this paperwork. Failure to submit the requested questionnaire to the insurance carrier will result in denial of claims and all balances will become the 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. 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 others 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 unpaid 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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Informed Consent for Examination and Treatment

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

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