CONSENT FOR USE OR DISCLOSURE OR HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purpose.

Along with this consent form, you will be given a copy of our privacy notice, if requested, that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorization at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____
Patient Signature

_____
Patient Name Printed

_____
Date

FOR OFFICE USE ONLY

_____
Authorized Provider Representative

_____
Date

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your Chiropractor and members of the practice staff may need to use your name, address, phone numbers, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request of we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information any may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you so not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice if effective as of date below. This authorization will expire seven years after this date on which you last received services from us.

I authorize you to use or disclose my health information in the manner describe above. I am also acknowledging that I have received a copy of this authorization.

_____
Patient Signature

_____
Patient Name Printed

_____
Date

FOR OFFICE USE ONLY

_____
Authorized Provider Representative

_____
Date

DISCLOSURE AND CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the patient: Insurance is a contract between you and the Insurance company. We will gladly file the insurance but ultimately you are responsible for your account.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays, on me (of the patient named below. For whom I am legally responsible) by the Doctor of Chiropractic and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic.

I understand and I am informed that, in the practice there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

<u>Payments</u>

Payment for services is due at time of treatment. If insurance company denies any/all charges you will be sent a bill in the mail for the remaining balance. Unpaid overdue accounts will be sent to Fox Collection Agency after 365 days of no payment activity from date of first bill send to patients address. I understand if my account is unpaid it will be sent to Fox Collection Agency. All bad debt accounts will have a 30% charge fee added to the account. It will be 30% of all account charges. If the account goes into the legal process the charge will be 40% charge fee added to the account. It will be 40% of all account charges. I understand I am responsible for the additional fees plus the balance.

_____
Patient Signature

_____
Patient Name Printed

_____
Date

<u>FOR OFFICE USE ONLY</u>

_____
Authorized Provider Representative

_____
Date