RESTORE
HEALTH & WELLNESS

PATIENT HEALTH INFORMATION CONSENT FORM

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We want you to know how your patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA rules and regulations online.

1. I understand and agree to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, I agree to allow this chiropractic office to submit requested information to the Health Insurance Company (or companies) provided to the office by me for the purpose of payment.

2. I have the right to examine and obtain a copy of my own health records at any time and request corrections. Also, I understand that I may request to know what disclosures have been made and submit in writing any further restrictions on the use of my PHI. However, this office is not obligated to agree to those restrictions. In addition, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

3. I understand that written consent need only be obtained one time for all subsequent care given to me in this office.

4. I may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

5. I understand for my security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in this office. This office has taken all precautions that are known by this office to assure that my records are not readily available to those who do not need them.

6. I have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. I grant permission to be contacted in order to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

8. I acknowledge that any insurance I may have is an agreement between the carrier and me, and that I am responsible for the payment of any covered or non-covered services I receive.

9. I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

10. I understand that my refusal to sign this consent for the purpose of treatment, payment, and health care operations, may consequently result in the chiropractic physician refusing to give me care as her right.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. In addition, to the best of my ability, the information I have provided on the Patient Intake Form is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

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Signature Date