FAMILY FRIENDLY CHIROPRACTIC

DOCTOR-PATIENT RELATONSHIP IN CHIROPRACTIC (All patients must sign)

I acknowledge that I have received a copy of the Doctor-Patient Relationship explanation and give my full consent to be treated by the attending doctor.

SIGNATURE: ________________________________ **DATE:** ________________

AUTHORIZATION FOR RELEASE OF INFORMATION (All patients must sign)

I certify that all the information I give is correct and I authorize Family Friendly Chiropractic and its participating physicians to release medical or financial information needed for this or a related claim to any named physician, insurer, payment plan (including Social Security Administration or its intermediaries) or other residential facilities. I further authorize Family Friendly Chiropractic to exercise discretion in responding to requests for my records and to deny requests which do not represent my interests at the time such requests are made.

SIGNATURE: ________________________________ **DATE:** ________________

ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF ACCOUNT (All patients must sign)

I hereby authorize payment directly to Family Friendly Chiropractic and its providing physicians, of benefits otherwise payable to me, including major medical insurance, agreeing that said assignment is irrevocable. I also authorize refund to the insurance company or health care payor of overpaid benefits where my coverages are subjected to coordination or benefits. I authorize any overpayment due me on this account to be first applied to any other unpaid balance I may have at Family Friendly Chiropractic. I understand that I am ultimately responsible to Family Friendly Chiropractic for payments of all charges incurred. I agree to pay my account, when due, in accordance with Family Friendly Chiropractic policy covering the payment of outstanding balance due. I also acknowledge that I received a copy of the financial disclosure statement.

SIGNATURE: ________________________________ **DATE:** ________________

CERTIFICATION AND AUTHORIZATION FOR MEDICARE PATIENTS (ALL PATIENTS WITH MEDICARE MUST SIGN)

I request payment of authorized Medicare benefits be made on my behalf for any services furnished to me by Family Friendly Chiropractic. I authorize any holder of medical and other information about me to be released to Medicare and its agents any information needed to determine these benefits for related services. I permit a copy of this authorization to be used in place of the original.

SIGNATURE: ________________________________ **DATE:** ________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 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 PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

Treatment: The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (of companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

Access: The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and can submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

Consent: A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

Revoke: The patient 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.

Security and Right to Privacy: For your 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 our office. We have taken all precauthios that are known by this office to assure that your records are not readily available to those who do not need them.

Violations of Policy: The patient has the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

Refusing Consent: The patient has a right to refuse to sign this consent form. However, if the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I acknowledge that I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

SIGNATURE: ________________________________ **DATE:** ________________