HIPAA Compliance Patient Consent Form

Our notice of privacy practices (on the back) provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

____Protected health information may be disclosed or used for treatment, payment, or healthcare operation

____The practice reserves the right to change the privacy policy as allowed by law

____The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions

____The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

____The practice may condition receipt of treatment upon execution of this consent

May we phone you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we leave a message at your employment? YES NO

May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment recommendations, relevant scientific articles and medical forms? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature:_____ Date:_____

Witness:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

**Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

**Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Offer.

**The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any person identifiable by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

**The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alterative locations.
**The right to inspect and copy your protected health information.
**The right to amend your protected health information.
**The right to receive an accounting of disclosures of protected health information.
**The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2003 and we are required to abide by the terms of this Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

The US Dept of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201 202-619-0257 or 1-800-696-6775

Financial Policy

Insurance Coverage

Welcome to **Complete Wellness Center, S.C.** Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

D._____I have been informed that my insurance will only be billed for acute injuries or conditions

E. _____I have been informed that my insurance does not cover maintenance care; therefore I assume full financial responsibility for all charges

Missed Appointments

It is the policy of **Complete Wellness Center, S.C.** to assess a **$60.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

1. In the event my insurance company does not pay within 30 days of billing. I will become personally responsible for the amount on the credit card listed below.
2. In those instances in which my insurance company has made partial payments, I authorize you to collect outstanding balances on the credit card listed below

Name on Card:_____ Mastercard or Visa

Card Number:_____ Exp:_____

Sec. Code:____ Signature:_____

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy. _____(initial)