



Patient Consent Form

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Notice of Privacy

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing.

Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. You have the right to request restrictions and revoke consent in writing after you have reviewed this privacy notice.

Print Name: _____ Signature: _____ Date: _____

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Insurance and Financial Information

Do you intend to use insurance? Yes No

If answered "Yes", please continue.

Are you listed as "primary" on your insurance? Yes No

If answered no, please provide the information below for the primary holder:

Name: _____ Relationship to patient: _____

Birthday: _____ Social Security Number: _____

Consent for payment

I understand that it is my responsibility to provide Trinity Chiropractic with my current insurance information. I also understand it is my responsibility to provide my insurance company with their requested information and by not doing so I may delay the processing of my claims or even cause claim denials. I agree to pay what my insurance charges me for chiropractic visits (my deductible, coinsurance, co-pays and any other items deemed "patient responsibility"). I also understand that it is not Trinity Chiropractic's responsibility to tell me about my insurance coverage and if I want those details I will call my insurance company directly. In the unlikely event that my insurance company does not pay due to non-coverage, or non-covered services, I agree to pay the unpaid balance.

Patient/Guardian Signature: _____ Date: _____