Patient 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 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 PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. I acknowledge receipt of the “Notice of Patient Privacy Policy”.

1. The patient understands and agrees to allow this 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 (or companies) provided to us by the patient for the 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.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient’s written consent need only be obtained one time for all subsequent care given the patient in this office.
4. 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.
5. 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 precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Signature:____ Date:________________________

CONSENT

Acknowledgment of Risks, Injury & Obligations: As a client, I acknowledge that the activity I am to undertake at Health Centered of Scottsburg, Inc. will expose me to certain risks. I acknowledge and understand that while participating in such activity; • I may be injured, physically or mentally, or may die • Any physical conditions I may have, could be exacerbated or intensified by my participation in the activity • My personal property may be lost or damaged • Other persons participating in such activity may cause me injury or may damage my property • I may cause injury to other persons or damage their property • The conditions in which the activity is conducted may vary without warning • I may be injured or die or suffer damage to my property as a result of the negligence or breach of contract by Health Centered of Scottsburg, Inc.• There may be no or inadequate facilities for treatment or transport of me if I am injured • I assume the full risk of and full responsibility for any injury, death or property damage resulting from my participation in the activity including, without limitation, any of the above situations.

Release and Indemnity: As a client, I participate in the activity at my sole risk and responsibility. I release, identify and hold harmless Health Centered of Scottsburg, Inc., its servants and agents, from and against all and any actions or claims which may be made by me or on my behalf or by other parties for or in respect of or in any way related to any injury, loss, damage or death caused to me or my property whether by negligence, breach of contract or in any way whatsoever. Medical contraindications of pregnancy, cancer, medically implanted device(s), epilepsy, severe hypertension, cardiovascular disease, renal disease, immune disease(s), and blood disorders/ diseases do not apply to my current health status. I acknowledge and agree that any vehicles, and their contents, parked in any car lot or elsewhere on the premise of Health Centered of Scottsburg, Inc. are left at the owner’s risk and Health Centered of Scottsburg, Inc. will accept no liability for loss, damage or theft. It is my responsibility to ensure that I correctly operate or use any facilities and/or equipment provided by Health Centered of Scottsburg, Inc. including the adjustment of levels or settings on the equipment. It is my duty to consult a member of staff before use, if I am in any doubt as to how to correctly operate any equipment. I also authorize the healthcare staff to perform the necessary services I may need.

Signature:____ Date:____________________

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the doctors and staff of Health Centered Chiropractic have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Signature:____ Date:____________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I herby authorize the release of all medical information requested by my insurance carrier, attorney, or other health care facility as needed. I also authorize Health Centered of Scottsburg, Inc. to obtain information from my insurance carrier, attorney, or other health care provider as needed.

Signature:____ Date:____________________