808 Caldwell Avenue, Suite 102; Portage, PA 15946 Phone: (814)736-9897 Fax: (814) 736-9880

PORTAGE CHIROPRACTIC PATIENT CONSENT

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that I am under the care and supervision of the attending doctor and it is the responsibility of the staff to carry out the instructions of such doctor. I further understand that the doctor and staff at Portage Chiropractic do not diagnose or treat medical conditions and will not be held responsible for any pre-existing medically diagnosed conditions, nor for any diagnosis. Portage Chiropractic uses open adjustment and therapy areas for all patients. I am aware that should the need for privacy arise (e.g. exam, discreet conversations, etc.) an enclosed private room within the office will be made available to me at my request.

Financial: I understand that Portage Chiropractic will verify my insurance coverage and review that information with me. However, I understand that my insurance policy is a contract between me, my insurance company and my employer (if applicable). Portage Chiropractic is NOT a party to that contract. As a courtesy to me, Portage Chiropractic will bill my insurance company directly. However, I am aware that it is my responsibility to fully understand my insurance coverage before receiving services at Portage Chiropractic. I understand that I am ultimately personally responsible for all charges. I authorize assignment of my insurance rights and benefits directly to Portage Chiropractic for services rendered.

Release of Information: By signing this form, I am granting consent to Portage Chiropractic to use and disclose my protected health information for the purposes of treatment, payment and health care operations. A *Notice of Privacy Practices* provides more detailed information about how Portage Chiropractic may use and disclose this protected health information. I have a legal right to review the document the *Notice of Privacy Practices,* which is kept at this office's front desk.

X-ray Release Policy: I understand that, if x-rays are taken in the office, the information gleaned from such x-rays is my property. I understand that Portage Chiropractic will, within three (3) business days, provide an x-ray report summarizing the doctor's findings to the health care provider of my choosing as long as I have signed the appropriate release form. This report is **subject to a $10.00 fee,** payable by me before the x-ray report is released. I understand that the hard copy x-rays are a part of my permanent health record and are the property of Portage Chiropractic. I understand that it is Portage Chiropractic's policy that **patients may not hand carry x-rays** to another health care provider. However, Portage Chiropractic will assume the cost of mailing the hard copy x-rays to the provider of my choice, provided I have signed the appropriate release form. **I understand that Portage Chiropractic will share my hard copy x-rays directly with any health care provider free of charge,** provided I have signed the appropriate release form and the receiving provider agrees to return the x-rays within thirty (30) days.

Medicare and Medicaid Consent to Release Information/Financial: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. Medicare and Medicaid do not cover examinations, x-rays, interferential stimulation or mechanical traction in a chiropractic office. I understand that Portage Chiropractic performs x-rays on-site and that, along with other non-covered services, the x-ray service is my financial responsibility.

Verification of Pregnancy (Female Patients Only):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

_____ _____
Print Patient's Name *Date*

By _____
Signature of Patient

By _____ **(if patient is a minor or under guardianship order as defined by State law)**
Signature of Parent / Guardian **(circle one)**

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PORTAGE CHIROPRACTIC
Where YOUR health is our #1 priority!

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

*We at Portage Chiropractic want you to know how your Patient Health Information **(PHI)** may 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. Before signing this document, 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 Notice of Privacy Practices that is available to you at the front desk.*

1. The patient understands and agrees to allow this chiropractic office to use his or her PHI for the purpose of treatment, payment, healthcare operations and coordination of care. Be assured that this office will limit the release of all PHI to the minimum required for payment or by law.
2. The patient has the right to examine and obtain a copy of his or her own health record at any time and to request corrections.
3. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of his or her PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
4. A person's written consent need only be obtained one time for all subsequent care given the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect 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. However, if the patient refuses to give consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
6. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
7. 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 have no need to see them. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS regarding any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains.
9. This notice is effective on the date stated below.

The undersigned patient does hereby acknowledge that he or she has received this summary of privacy practices pursuant to HIPAA and has been advised that a full copy of Portage Chiropractic's Notice of Privacy Practices is available for review upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA and State Law and Federal Law.

By _____ _____
Signature of Patient Date

If patient is a minor or under a guardianship order as defined by State law:

By _____ _____
Signature of Parent / Guardian **(circle one)** Date