HIPAA/Patient Health Information Consent

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 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 Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (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 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 to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. 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.
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 operation, the chiropractic physician has the right to refuse to give care.
8. We have an open front desk and all of our financial arrangements are discussed at the front counter. If you feel that you need a more private place to discuss your financial arrangements we can always move to a private room. Please notify the office staff or doctor if any arrangements need to be made.
9. When you refer a patient to our office you will be recognized by first name, last initial on our Thank You Board, Article of the Month, and Thank you/referral letters.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may design as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employee of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

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

INSURANCE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby direct all insures and other persons responsible for the this PATIENT'S health care cost to make all payments for health care services rendered by Shelton Chiropractic directly to Shelton Chiropractic. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account upon receipt. I certify this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized. I also understand if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. I also agree, any and all checks sent to me directly from my insurance company for services rendered at this chiropractic office, will be sent to 7924 Preston Rd Suite 300, Plano, TX 75024 and will be credited to my account. Furthermore, if I fail to return said insurance payments, I agree I will be held liable for any attorney fees incurred by Shelton Chiropractic to recover said payments.

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Signature of Patient/Guardian **Date**

Texas State law requires that we inform you in writing of your charges at each visit. Please indicate below your choice of receiving a paper receipt detailing the charges for each visit.

Please initial below:

_____ **Yes**, I would like a printed Appointment Receipt at each visit. By checking this box, I understand that it is my responsibility to request this at check out.

_____ **No**, I do not wish to receive any of my printed Appointment Receipts. I understand that I may request any Appointment Receipt for any date of service at any point in the future.