## ASSIGNMENT

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO COMPLETE CHIROPRACTIC OF SOUTH HILLS THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICE RENDERED BY THIS CLINIC. IN THE EVENT THAT MY POLICY PROHIBITS ASSIGNMENT, I AGREE TO BRING THE INSURANCE CHECKS INO THIS OFFICE WITHIN FIVE DAYS SO THAT MY BALANCE MAY BE CREDITED.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORGINAL.

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PATIENT/GUARDIAN SIGNATURE DATE

## RELEASE OF INFORMATION

I AUTHORIZE THIS CLINIC TO RELEASE ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, AND ATTORNEY INVOLVED IN THIS CASE; AND HEREBY RELEASE THIS CLINIC OF ANY CONSEQUENCE THEREOF.

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PATIENT/GUARDIAN SIGNATURE DATE

## FINANCIAL RESPONSIBILITY

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS CLINIC INCLUDING MY INSURANCE DEDUCTIBLE, COPAYMENT, AND ANY SERVICE OR PRODUCT REJECTED BY MY INSURANCE COMPANY.

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PATIENT/GUARDIAN SIGNATURE DATE

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PART WHO ACCEPTS ASSIGNMENT BELOW.

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PATIENT/GUARDIAN SIGNATURE DATE

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED ON CLAIM FORM.

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PATIENT/GUARDIAN SIGNATURE DATE

PLEASE TURN OVER FOR MORE INFORMATION AND SIGNATURES, THANK YOU

**PATIENT HEALTH INFORMATION CONSENT FORM**

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.

- 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 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.
- 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 OBLIGATED TO AGREE TO THOSE RESTRICTIONS ONLY TO EXTENT THEY COINCIDE WITH STATE AND FEDERAL LAW.
- A PATIENT'S WRITTEN CONSENT NEED ONLY BE OBTAINED ONE TIME FOR ALL SUBSEQUENT CARE GIVEN THE PATIENT IN THIS OFFICE.
- 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.
- OUR OFFICE MAY CONTACT YOU PERIODICALLY REGARDING APPOINTMENTS, TREATMENT, PRODUCTS, SERVICES, OR CHARITABLE WORK PERFORMED BY OUR OFFICE. YOU MAY CHOOSE TO OPT-OUT OF ANY MARKETING OR FUNDRAISING COMMUNICATIONS AT ANY TIME.
- 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.
- PATIENTS HAVE THE RIGHT TO FILE A FORMAL COMPLAINT WITH OUR PRIVACY OFFICIAL AND THE SECRETARY OF HHS ABOUT ANY POSSIBLE VIOLATIONS OF THESE POLICIES AND PROCEDURES WITHOUT RETALIATION BY THIS OFFICE.
- 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. YO UWILL BE PROVIDED WITH A NEW NOTICE AT YOUR NEXT VISIT FOLLOWING ANY CHANGE.
- THIS NOTICE IS EFFECTIVE ON THE DATE STATED BELOW.
- 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.

I HAVE READ AND UNDERSTAND HOW MY PATIENT HEALTH INFORMATION WILL BE USED AND I AGREE TO THESE POLICIES AND PROCEDUTES.

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PATIENT/GUARDIAN SIGNATURE DATE

FOR FURTHER INFORMATION REGARDING THIS NOTICE, PLEASE CONTACT OUR DOCTOR AT 724-785-7633.