

Combs Chiropractic & Wellness Center

PATIENT CONSENT FOR USE AND/OF DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Combs Chiropractic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Combs Chiropractic to provide treatment to me, and also necessary for Combs Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. Combs Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Combs Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that may be used by Combs Chiropractic: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering phone.
4. Combs Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Combs Chiropractic to treat me and obtain payment for that treatment, and as necessary for Combs Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Combs Chiropractic restrict how my PHI is used.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that Combs Chiropractic has already taken action in reliance on this consent.
7. **INSURANCE AGREEMENT:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Combs Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Combs Chiropractic & Wellness Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
8. **AUTHORIZATION AND ASSIGNMENT:** I request payment of government benefits to myself or the party who accepts assignment. I authorize payment of medical benefits directly to Combs Chiropractic & Wellness Center for services to be rendered.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if minor):

Signature of Individual

Relationship

Date Signed ____/____/____

Witness: _____