NOTICE OF CONSENT

I understand that I have certain rights to privacy regarding my health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment
- Obtaining payment from third party payers (insurance company)
- The day to day healthcare operations of Advance Chiropractic Clinic

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

- I authorized Dr. Robin Robbins to perform diagnostic procedures and treatment as may be necessary for the delivery of proper chiropractic care.
- I authorize release of any information concerning my (or my child's) health care, for the advice and treatment provided for purpose of evaluation and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment to another chiropractor, or another healthcare professional and their staff.

FINANCIAL RESPONSIBILITY

- I hereby authorize payment of insurance benefits directly to Advance Chiropractic Clinic, otherwise payable to me.
- I understand that Advance Chiropractic Clinic staff will estimate insurance benefits as close as possible. I understand that I am responsible for the payment of the account, and providing correct insurance information.
- I understand that if insurance is not applicable when services are rendered, then full payment is due at the time of service.

REMINDER CALLS AND MISSED APPOINTMENTS

PLEASE INDICATE YOUR PREFERENCE

Phone call: Yes / No			
Home:	Work:	Cell:	
Text Message: Yes / No	Email: Yes/No		
Cell:		<u>a</u>	.com
Print Name:			
Signature:		Date:	