HIPAA/Consent Form

_____**:** By signing this form you acknowledge that Wilhelm Chiropractic has provided you a copy of our Notice of Privacy Practice. You have the right to review our Notice before signing this consent. The terms of our Notice may change and you obtain a revised copy by contacting or office

If you ever believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

_____**:** By signing this form, you acknowledge that by presenting yourself or a child (to whom you are the parent or legal guardian of) as a patient you consent to chiropractic care by the doctors and staff of Wilhelm Chiropractic. You hereby grant full authority to the chiropractor and their respective assistants to administer and perform any and all treatments, test, or diagnostic procedures to or upon me, which may be advised or necessary. The information and Notice of Privacy Practices is made available on request.

_____**:** By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You give your consent to obtain payment from third party payers. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my Doctor to act as my agent in helping me obtain payment for my insurance and/ or Medicare and I authorize payment of these benefits directly to Wilhelm Chiropractic, LLC on my behalf for any services furnished.

_____**:** By Signing below, I Understand and agree that regardless of my insurance, I am ultimately responsible for the balance on my account for services rendered and products purchased.

"By signing this form I understand the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and understand that I have granted the chiropractor and staff permission to perform treatment, tests, or diagnostic procedures that may be advised as necessary."

Patient Name:_____

Relationship to patient:_____

Signature:_____ **Date:**_____