SUNRICE
FAMILY + SPORT
CHIROPRACTIC LLC

Dr. Larissa M. Rice DC
717 Commercial St.
Atchison, KS 66002
Phone: 913.367.1665

## Consent of Professional Services and Release of Information

I hereby authorize Dr. Larissa Rice DC and whomever she may designate as her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that she deems necessary in any case (or on the patient named below, for whom I am legally responsible). I also give my consent to Sunrice Chiropractic LLC to consult other doctors and/or radiologists to assist in diagnosis and treatment. I have had an opportunity to discuss with Dr. Rice DC and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and I am informed, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor of chiropractic to be able to anticipate and explain all risks and complications. I instruct the chiropractor to deliver the care that, in her professional judgement can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

## Payment Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this chiropractic office 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 this chiropractic office will be credited to my account upon receipt. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

## Use and Disclosure of your Protected Health Information

I understand that my Protected Health Information will be used by Sunrice Chiropractic LLC or may be disclosed to others for the purposes of treatment, obtaining payments and reimbursement, or supporting the day-to-day health care operations of this office.

## Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
I have read a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

## Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

## Notice of Treatment in Open or Common Areas

Private areas farther away from the waiting room are available upon request.

## Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

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**Appointment Reminders and Health Care Information Authorization**

Your chiropractor and members of the staff may need to use your name, address, email address, phone number, and your clinical records to contact you with appointment reminders or rescheduling, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. I grant permission to have my name used on Sunrice Chiropractic's referral board and to be sent occasional cards, letters, special promotions, reminders, emails or health information to me as an extension of my care in this office. You have the right to refuse this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. _____ Patient Initials

I, _____, give permission to all my health care and medical service providers and payers to disclose and release my Protected Health Information to those named below:

| **Name(s):** | **Relationship:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**I have read, or have read to me, the above consent (pages 4 & 5). I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures and give permission to use and disclose my health information. I intend for this consent to cover the entire course of treatment for my present condition and for any future condition(s) for or which I seek treatment (or for the patient named below, for whom I am legally responsible).**

_____ _____
Patient or Legally Authorized Individual Signature — Date

_____ _____
Print Patient's Full Name — Time

_____ _____
Witness Signature — Date