Morris CHIROPRACTIC

Consent for purposes of Treatment, Payment and Healthcare Operations:

I consent to the use or disclosure of my protected health information by Morris Chiropractic Office for the purposes of evaluating and providing chiropractic treatment to me, obtaining payment for my health care bill or conducting health care operations of Morris Chiropractic Office. I understand that evaluation or treatment of me by Morris Chiropractic Office may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Morris Chiropractic Office is not required to agree to the restrictions that I may request. However, if Morris Chiropractic Office agrees to a restriction that I request, the restriction is binding on Morris Chiropractic Office.

I have the right to revoke this consent, in writing, at any time, except to the extent that Morris Chiropractic Office has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my doctor, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Morris Chiropractic Office HIPAA Notice of Privacy Practices prior to signing this document. The Morris Chiropractic Office HIPAA Notice of Privacy Practices has been provided to me upon my request. The HIPAA Notice of Privacy Policies describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Morris Chiropractic Office. The HIPAA Notice of Privacy Practices for Morris Chiropractic Office is also available at the front desk. This HIPAA Notice of Privacy Policy also describes my rights and Morris Chiropractic Office duties with respect to my protected health information.

Morris Chiropractic Office reserves the right to alter the Morris Chiropractic Office HIPAA Notice of Privacy Practices in order to reflect any changes to the federal HIPAA policies. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient/Guardian Initials:_____

Financial Arrangements and Policies:

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient/Guardian Initials:_____

Insurance Billing Payment:

Patients are ultimately fully responsible for products purchased and services provided by our office. Our office is a participating provider with a number of insurance companies. For your convenience, our office will make an effort to verify your insurance benefits. However, ultimately it is the patient's responsibility to determine benefit and authorization information before services are rendered. Please note that verification of benefits is not a guarantee of benefits. Your insurance company makes the final determination of insurance benefits when they consider the claim. It is understood that despite our best efforts to provide you with a financial estimate of the cost of care, times arise where insurance companies do not reimburse what was originally quoted. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company. If a referral is required but not provided at the time of your visit, full payment is expected at the time of service. Your signature below will give power of attorney to endorse checks made to_____ to be credited to your account.
(insert patient's name)

Patient/Guardian Initials:_____

Release of Information:

The undersigned authorizes Morris Chiropractic Office whether signing as patient or guardian to release medical information as requested by insurance companies, employers, and other responsible parties, unless otherwise directed. If authorization to release information is denied, payment for services rendered will be due at the time of services.

Patient/Guardian Initials:_____

Informed Consent to Chiropractic Care:

I request and consent to the performance of chiropractic examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by Dr. Morris and/or licensed chiropractor/therapist deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Initials:_____

Missed Appointments:

All missed appointments are documented in your chart. If no effort has been made to reschedule, Morris Chiropractic Office will attempt to contact patient. After the third failed attempt to schedule patient, the office will contact the referring physician if applicable and advise discharge from chiropractic treatment due to non-compliance by the patient. This policy helps insure the treatment necessary for fast recovery and we appreciate your cooperation with this policy.

Patient/Guardian Initials:_____

Assignment of Insurance Benefits:

The undersigned agrees, whether signing as patient or guardian, direct payment to Morris Chiropractic Office of any insurance benefits otherwise payable to or on behalf of the undersigned for evaluation and treatment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. I understand that any co-pay or share or cost will be charged and I am responsible for payment for any such charge that may be due. All co-pays are due at the time of service.

Patient/Guardian Initials:_____

Patient/Guardian Authorization for Treatment:

I hereby grant my consent for chiropractic evaluation and treatments rendered by Morris Chiropractic Office. Also, my initials indicate that I have read and acknowledge the above topics, respectively.

Patient/Guardian Name:_____

Patient/Guardian Signature:_____Date:_____