SKYLINE

CHIROPRACTIC

Chiropractic for Children and Adults

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your record will be used. If you would like to have a more detailed account of your policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. At this time the Privacy Rule does not require our office to provide private rooms. However, we are required to determine what steps are reasonable to safeguard patient information either oral and/or written. To protect your rights we will provide a private room for any special request that you may have. All routine visits will remain in the community adjusting area (tables 1-9).
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
9. This signature gives Skyline Chiropractic permission to use any or all facts (including my photograph) for office marketing purposes or promotional material. If this is a problem, just make a note on the signature line.
10. Please provide Skyline Chiropractic with your Email address. Your Email will not be shared. It is for Skyline Chiropractic use only.

Email: _____

Patient's SS# XXX-XX- Last 4 digits

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Name of Patient **Signature** **Date**

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