HIGHLAND CHIROPRACTIC

AUTHORZATION AND CONSENT FOR MEDICAL TREATMENT, PAYMENT GUARANTEE, AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

GENERAL CONSENT FOR MEDICAL TREATMENT: As a patient of **HIGHLAND CHIROPRACTIC**, I understand that the clinic has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize the clinic, and its affiliated physicians and other licensed providers to order and/or provide direct and indirect services in efforts to diagnose and treat diseases, disorders, injuries or other conditions. I understand that the providers will act in good faith to provide quality care and treatment. However, a specific cure or resolution cannot be promised. My patient rights include my participation in my care plans and treatment options. I may revoke this consent for general treatment. Additional informed consent shall be given for medical procedures or treatments for which I need to specifically consent.

REASSIGNMENT OF BENEFITS AND PAYMENT GUARANTEE: I authorize **the clinic** to bill my insurance company or other designated third-party payer for the services provided as related to my care. I acknowledge that the clinic will file claims on my behalf as a courtesy and that I, as guarantor of the account, remain responsible for payment of services. I acknowledge that I am also responsible for deductibles, co-insurance amounts, co-payment amounts, and non-covered services. I/we agree to pay the established rates of the clinic for all services rendered for the patient named below. I also acknowledge that I am aware that the clinic may have policies for financial counseling and assistance.

RELEASE OF MEDICAL INFORMATION FOR TPO AND EMERGENCY CARE: I do hereby authorize **the clinic** to release medical or other information to any insurance company or third-party for which reassignment of my benefits has been made for a medical service. I understand that my information may be released by law for any business activity related to the treatment, payment and operation (TPO) related to my care. I also authorize the healthcare providers of the clinic to release medical and other information to other healthcare providers or facilities as needed for emergency treatment or continuity of care. Unless otherwise restricted by the me, as patient or guardian, health information may also be released to immediate family members who are actively engaged in the management of my care. In all other cases, I understand that I will be required to authorize the release of protected health information (PHI) for any other reason.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT: By signing this form, I acknowledge receipt of the notice of privacy practices of **the clinic.** Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this Notice. If you have any questions about our notice of privacy practices, please contact us at the above telephone number.

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND AUTHORZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS. THIS AUTHORIZATION/ACKNOWLEDGEMENT REMAINS IN FORCE UNTIL SUCH DATE THAT IT IS REVOKED OR REPLACED.

Patient Name:_____ Date of Birth_____

Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date: _____

Relationship of Signer to the Patient: ☐ Parent/Guardian ☐ Spouse ☐Grandparent ☐Other Relative