HIPAA / Notice of Privacy Practice

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws (45 CFR 1654). Patient confidentiality and privacy/security applies to and protected health information (PHI). Federal Laws now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their release of medical records.

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)

By signing this form, I acknowledge that I received or have been offered a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept at the front desk. At this time, I do not have any questions regarding my rights or any of the information I have received.

In order for the office to communicate with a family member, spouse, friend, or significant other by telephone, or verbally to a person who is in attendance with the patient in the doctor's office, the patient needs to authorize this communication. Any disclosure of protected health information (PHI) to another person requires this signed and dated authorization. If you have any aspects of your PHI that you do not want disclosed, please list the specific aspects of your PHI below that you want "restricted." This authorization may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing.

I authorize the doctor/staff to verbally communicate with the following person:

Name of Emergency Contact: _____

Telephone number: _____

□ My complete health record

□ My complete health record, with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment

□ Other (please specify): _____

_____

Patient (or Representative) Signature Patient Name Date

AUTHORIZATION FOR USE OF NAME AND/OR PHOTOGRAPH FOR MARKETING PURPOSES

Our office may like to use your name and/or photograph for marketing purposes. Our office needs your signed and dated permission to use your name or photograph to be compliant with new HIPAA patient privacy federal laws. We love to share photos, stories, or progress on our Social Media page(s) or website in the interest of bringing wellbeing to new patients. This authorization may be revoked at any time, by advising our office of this revocation in writing.

□ YES, I authorize use of my name and/or photograph □ NO, I do not authorize use of my name and/or photograph

_____

Patient (or Representative) Signature Printed Name Date

INFORMED CONSENT - Chiropractic Adjustments, Modalities, and Therapeutic Procedures

You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether to undergo the procedure after knowing the potential risks and hazards involved.

I have been advised that the chiropractic adjustments, modalities, and therapeutic procedures performed in this office, like all forms of health care, holds certain risks. While the risks are most often very minimal, there are some risks to exam and treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and increased symptoms/pain, or no improvement of symptoms/pain. I also acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Treatment objectives, as well as the risks associated with chiropractic adjustments and, all other procedures provided at Northwest Wellness Center have been explained to me to my satisfaction, and I have had an opportunity to ask questions. All my questions have been answered fully and satisfactorily, and I have conveyed my understanding to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the Doctor of Chiropractic named (and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named) deems necessary to treat my condition at any time throughout the entire clinical course of my care.

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Patient (or Representative) Signature Patient Name Date

AUTHORIZATION FOR TREATMENT-THERAPY IN A MULTI-PATIENT AREA

All initial history, examination, and report of findings are done in a separate room in a confidential setting. However, our office utilizes treatment and therapy areas that allow for more than one patient to be present at the same time during a treatment session. This open area will allow patients to see each other and overhear what is being said and done. If you want to discuss anything that you do not want to be overheard, please inform the staff before you see the doctor so a private room can be arranged. Our office needs your authorization to treat you in this open area. If you do not authorize this, our office will make arrangements for your privacy. This authorization may be revoked by you at any time, by advising our office of this revocation in writing. If you choose to not sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

□ **YES**, I authorize open treatment-therapy area □ **NO**, I desire to have treatment in a private setting

FINANCIAL POLICY

Our policy requires payment in full for all services rendered at the time of visit. Every patient is recommended to have a card on file in our system and if that card were to decline and a small balance accrue, you will have **1 week** to pay off balance or you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting on your account.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Northwest Wellness Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Northwest Wellness Center will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me, and I am personally responsible for payment.

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Patient (or Representative) Signature Printed Name Date