Patient Health Information Consent Form

We want you to know 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 read and sign this consent form stating that you understand and agree with how your records will be used if you would like to have more detailed account of our policies and procedures concerning the privacy of your personal health information we encourage you to read the HIPPA procedures that are in our front waiting area.

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 the example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) proved 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 agrees to allow this chiropractic office to use their image, likeness, and/or sound of their voice as recorded on audio or video tape, without payment or any other compensation from Stinnett Chiropractic, for educational, marketing, or social media publishing.
3. The patient has the right to examine and obtain a copy of his/her 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.
4. A patient's written consent need only be obtained one time for the subsequent care given to the patient by this office.
5. The patient may provide a written request to revoke consent. This request would not apply to care given prior to when the written request was presented.
6. For your security and right to privacy, all the staff has been trained in the area of patient records 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.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these procedures and policies.
8. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, our office has the right to refuse to give care.

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

Full Name____________________________ Signature_________________________________ Date__________

Witness Name__________________________ Signature_______________________________ Date___________

For Insurance Recipients Only

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand Stinnett Chiropractic will file claims to my insurance carrier as a courtesy and will prepare any necessary reports and forms to assist in making collections from the insurance carrier. 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.

Full Name____________________________ Signature_________________________________ Date__________