PATIENT HEATLH INFORMATION CONSENT FORM

HIPPA Privacy Information

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our Privacy Notice, please understand that we have and always will respect the privacy of your health information. At your request, we will give you a copy of our complete Privacy Notice. Draggoo Chiropractic, S.C. does reserve the right to change our policy practices as described in the notice. If any future changes are made to our privacy practices, we will notify you in writing.

Initials: _____

Wisconsin Chiropractic Association Authorization (WCA)

Authorized staff of Draggoo Chiropractic, S.C. may also need to disclose your name, address, phone number, billing information and your clinical records to the WCA. Due to possible problems with improper insurance claims processing or for assistance in receiving reimbursement for our services to you, your PHI may need to be disclosed to the WCA with your authorization. By signing this form you are giving us authorization to send the WCA your PHI. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. You may restricted the individuals or organizations to which your PHI is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide or the methods we use to obtain reimbursement for your care.

Initials: _____

Marketing Authorization

From time to time**, our office may mail you information** to make you aware of special offers related to products or services, and events that may interest you. Your authorization is required to provide the following products and/or services to you; birthday cards, congratulations cards; food-drives, newsletters, coupons, coupon books, brochures, surveys, etc.

Initials: _____

Consent for Use or Disclosure of Health Information

Following are possible circumstances in which we may have to use or disclose your PHI (Patient Health Information):

- We may have to disclose your PHI to another health care provider or hospital if it is necessary to refer you to them for diagnosis assessment or treatment of your health condition.
- We may have to disclose your PHI and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our office for quality control or other operational purposes.

Initials: _____

Appointment Reminders and Health Care Authorization

Authorized staff of Draggoo Chiropractic, S.C. may need to use your name, address, phone number, billing information and your clinical records to contact you with appointment reminders, information about treatment alternatives or other PHI. If this contact is made by phone and you are not home, a message will be left on your answering machine or voice mail. By signing this form, you are giving us authorization to contact in this manner. As well, you may restricted the individuals or organizations to which your PHI is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to revoke your authorization. In addition, your authorization to give us your PHI allows us to disclose that information to your insurance company for benefit verification or claims processing. You have the right to refuse to give us this authorization. If you not give us authorization, it will not affect the treatment we provide to you but if may affect reimbursement by your insurance company.

Patient Name (Signature) Patient Name (Printed) Date

Authorized Provider Representative (Signature) Date

Chiropractic Care Center of New Berlin
15720 W. National Avenue
New Berlin, WI 53151