

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by ACCIDENT & SPORTS INJURY CLINIC or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (Print)

Signature

Date

Signature of Patient Representative

Relationship to Patient

Office Representative

Date

OFFICE POLICIES

To help you receive our best, ALL patients are accepted for care based on the following policies.

REFERRALS:

The greatest honor a patient can give to their doctor is the referral of their family and friends.

We promise to give your loved ones the same quality, love and attention that you receive. Thank you in advance.

PREFERRED HOURS:

The doctor has set hours for adjusting and consultations. This allows better adjustments for you with less waiting. Consultations are set times to do exams, reports, or answer questions from you and those you refer. Your questions are always welcome.

Hours of Operations are:

Monday: 9:00 AM - 4:30 PM

Tuesday, Wednesday, Friday: 9:00 AM - 6:30 PM

Thursday: 9:00 AM - 5:30 PM

Lunch Hours are 11:45 PM - 2 PM Everyday.

APPOINTMENT SCHEDULING:

To save time, we ask that you pre-schedule all your appointments in advance. Please refrain from repeatedly rescheduling appointments within a 24 hour period.

BROKEN APPOINTMENT FEE:

Our policy for broken appointments is a \$25 charge for "no show" appointments, if you fail to notify us 24 hours in advance. In order to keep your progress on schedule, missed appointments need to be made up within 24 hours. If you repeatedly miss or reschedule appointments, we will regretfully have to discharge you from our care.

FINANCIAL AGREEMENTS:

It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If, for any reason, you can't keep your financial agreement, inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

TERMINATING YOUR CARE:

In the event you choose to discontinue your care for any reason, or we regretfully find it necessary to discharge you from our care, any outstanding fees become immediately due and payable.

OCCASIONALLY:

It is necessary for Dr. Mitchell to be away from the office for conferences, continuing education seminars, or vacations.

DISCOURAGEMENT:

Remember that healing and spinal correction takes time. If any time during your care, you do not feel that you are responding as well as you expected, please discuss it immediately with the doctor. We want you to get the most from your chiropractic care!

CONTACT:

Our office may periodically contact you by **phone, mail, email, or text** in regards to:

- Special Promotions/Events
- Birthdays
- Appointments

I have read and hereby accept the above policies.

Patient Signature

Guardian's Signature

Date