

CHIROPRACTIC HEALING HANDS

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

A partial list of your rights includes but is not limited to allowing (or prohibiting) health care providers from revealing information with your permission, as necessary, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing services rendered.

Information includes but is not limited to medical records, diagnostic reports, treatments, tests and results, billing, and referrals, as well as personal data such as birth date, etc.

We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. We will gladly explain all aspects of your care to you or assigned persons as you wish.

Please sign and return lower portion.

Privacy Policies of Healing Hands Chiropractic, LLC

The health Insurance Portability and Accountability Act (HIPAA) is in effect. HIPAA has certain requirements with which health care providers are required to comply.

We are required to give each patient a notice of Privacy Practices (see above) listing in which we might use your Protected Health Information. Please sign below, hereby stating that you received the notice, and return the lower portion to us.

Thank you for helping us comply with these regulations.

Patient Name (printed): _____

Patients Signature: _____

Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.

Today's date: _____ Signature of Patient: _____

If patient required assistance to complete information forms, please sign below and state your relationship to the patient.

Today's date: _____ Signature: _____

Relationship: _____