CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS

PATIENT CONSENT

TO OUR PATIENTS: Before you begin treatment at Proactive Wellness and Chiropractic Center, SC, the law requires that we explain your rights and responsibilities while a patient at the office. If you have a complaint or concern about your case, please discuss it first with you care provider. Please read and sign the form below. Ask questions if you do not understand.

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, x-rays, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatments, and that I have the right to refuse the recommended treatment.

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW: I understand that it is important that my medical providers have access to any of my medical records which will help them to safely treat me and manage my medical care. I agree that a copy of my medical records may be sent to any of my physicians or health care providers. This includes release to any hospital in which the office may be contacted for purposes of medical care and for the business operations relating to my health. I also agree that the office can release my medical records to accrediting or regulatory agencies if those agencies request my records and if the law allows those agencies access to my records.

INSURANCE/MEDICARE/MEDICAID ASSIGNEMNT OF BENEFITS PAYMENT OF MEDICAL BILLS: I would like a "third party payer" to pay the bills for my services at the office, to extend the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the "third party payer" be made to the office on my behalf for any services furnished to me by or in the office. I assign the benefits payable for physician services to the physician or organization furnishing the services. In consideration of clinic visits, I agree to pay the office for all charges not covered by any third party payer.

RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES: In many instances, a "third party payer" will pay a portion of my medical bill related to today's visit. Examples of "third party payers" are medical and auto insurance companies, workers' compensation insurance carriers, Medicaid, Medicare or its related organizations. In order for a "third party payer" to pay any or all of my bills related to today's visit at the office, I understand the "third party payer" may require information about the medical care and treatment I receive. I authorize the office to release to the "third party payer" any information needed to determine the payments related to the medical treatment I receive.

PATIENT'S RIGHT TO PRIVACY: I acknowledge that I have been made aware of the office privacy practices. If I would like a copy of the office's privacy regulations, I will ask for one. I understand I have the right to revoke this consent, in writing, at any time except where Proactive Wellness & Chiropractic Center, SC has already made disclosures in reliance of this consent.

SIGNATURE:_____**PRINT NAME**:_____

GUARDIAN:_____ **DATE:**_____