<u>Advance Notice of Possible Non Covered Services</u>

Below is a list of some of the services our office provides:

1. Spinal manipulations
2. Trigger point therapy
3. Cold laser therapy
4. X-rays
5. Exam
6. Detox baths

Some or all of the above services may not be covered by your insurance. It may not be certain until your insurance is billed.

It is the patient's responsibility to give us “**correct and current**” insurance information. If you have more than “1” insurance, it is your responsibility to know which is primary and which is secondary. This information is needed on your first
visit. We bill based on the information you give us. If nonpayment results in your incorrect information, *you will be financially responsible*. <u>Please inform us **immediately** if there is a change in your insurance.</u>

I ____________________________ have read and understood the above information. I will be personally responsible for any non covered services that I receive.

Date: ____________

Signature: ____

Puyallup Chiropractic Clinic
111 East Stewart Avenue
Puyallup, WA 98372

General Consent for Purposes of Treatment, Payment, and Healthcare Operations

I hereby consent to the use and/or disclosure of my protected health information by Puyallup Chiropractic Clinic for the purposes of Treatment, Payment, and Healthcare Operations. I understand that protected health information includes the following:

- Health records describing my health history, symptoms
- Demographic information
- Examination and test results
- Diagnosis
- Treatment
- Plans for the future medical care

And that this information serves as:

- A means for communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bills.
- A basis for diagnosing, and planning my care and treatments.
- A means by which a third party can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality reviewing the competence of healthcare professionals.

I further understand that:

1. Puyallup Chiropractic originates and maintains protected health information as part of my healthcare, including but not limited to information that may have been obtained from another healthcare provider, clearinghouse, health plan, or employer.

2. I have the right to review Puyallup Chiropractic's Notice of Privacy Practices (which describes Puyallup Chiropractic's protected health information use and disclosure practices) before I sign this document.

3. I have the right to request a restriction as to how my protected health information is used to carry out treatment, payment, or health care operations, however Puyallup Chiropractic is not required to agree to the restrictions requested.

4. I have the right to revoke this consent at any time in writing. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.

5. Puyallup Chiropractic Clinic reserves the right to change the Notice of Privacy Practices at any time. I have the right to obtain a copy of any revised notice upon request.

Restrictions

☐ No restrictions to the law requested

☐ I request the following restriction(s) on the use or disclosure of my health information:

____

____

Patient Name: ______________________________ Patient ID#: ____________________

______________________________ Date: ____________________

Signature of patient or Legal Representative

______________________________ ______________________________

Printed name of Patient's Representative (if applicable) Relationship to Patient (if applicable)

______________________________ ______________________________

Signature of Witness Date