Achievement Chiropractic

Patient Privacy, Informed Consent and Non-Insurance Billing Statement

I give Achievement Chiropractic permission to provide chiropractic services to me in an open room where other patients are also receiving chiropractic care. I am aware that other persons in the area may overhear some of my protected health information during the course of care. Should I need to speak with the doctor in private, an appointment can be made to provide a convenient time for these conversations.

I give permission to Achievement Chiropractic to use my address, phone number and clinical records to contact me with notifications, birthday cards, holiday related cards, information about chiropractic services and other health related information.

If Achievement Chiropractic contacts me by phone, I give permission to leave a message on an answering machine or in voice mail.

I hereby direct that Achievement Chiropractic shall **not** submit any billing data or related claim(s) for, or on my behalf, to any private insurance program, Medicare or any secondary Medicare Insurance Program carrier with whom I have insurance coverage.

I hereby acknowledge that I will be financially responsible to remit payment in full for all services provided to me at Achievement Chiropractic.

I give Achievement Chiropractic permission to access my patient care records in accordance with all applicable laws when necessary.

By signing this form, I understand the informed consent and are giving permission to use and disclose my protected health information in accordance with the directives above.

_____ _____

(Patient Printed Name) (Date)

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(Patient Signature)