CONSENT FOR USE OR DISCLOSURE, AUTHORIZATION AND ASSIGNMENT

Our Privacy Pledge

We are very committed to protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information. For example, we may have to disclose your health information to another health care provider or a hospital or to another party if they are potentially responsible for the payment of your services.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign our consent form. We reserve the right to change our privacy practices as described in that notice. Please feel free to call us at any time for a copy of our current privacy practices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Assignment of Payment

I understand that if it is determined that either there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor; or make provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney: the payment of services rendered by the doctor at Progressive Chiropractic will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

I have read your consent policy and agree to it's terms.

_____ _____

Patient Name (Please Print) Patient Signature

_____ _____

Date Signed Witness