Notice of Privacy Practices and Patient Consent for Use and Disclosure of

Protected Health Information

_____ _____

Patient Name (please print) ***Date***

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Bi-County Chiropractic may use and disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling and billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other use and disclosures of this information without my authorization.

Bi-County Chiropractic has a detailed document called the "Notice of Privacy Practices." It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, Bi-County Chiropractic will provide me with the most current Notice of Privacy Practices.

With my consent, Bi-County Chiropractic may call my home or other designated location and leave a message on the voice mail or in person in reference to any items that assist the practice such as appointment reminders, insurance items and any other calls pertaining to my clinical care, including x-ray or MRI results among others.

With my consent, Bi-County Chiropractic may mail to my home or other designated locations any items that assist the practice such as appointment reminder cards and patient statements.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Bi-County Chiropractic to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Bi-County Chiropractic has taken action relying on this consent.

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Signature of Patient or Legal Custodian/Authorized Representative Date

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Relationship to Patient if signed by another party

You may obtain a copy of our Notice of Privacy Practices at any time.
Bi-County Chiropractic