



# FORTIER CHIROPRACTIC HEALTH CARE

*“Life Without Limits”*

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## HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

### **THIS NOTICE DESCRIBES HOW RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW CAN GET ACCESS TO THE INFORMATION**

In the course of your care as a patient at our office we may use or disclose personal and health related information about you in the following ways: **1)** Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment of treatment. **2)** Your health records as well as your billing records may be disclosed to another party, such as insurance carrier (HMO, PPO, etc.) or your employer (if they are responsible for payment). **3)** Your name, address, phone number, and your health records may be used to contact you regarding appointment reminder, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- \* If we are providing health care services to you based on the orders of another health care provider.
- \* If we provide health care services to you in an emergency.
- \* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to.
- \* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive Chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. By signing below, I acknowledge that I have read the above information and give full disclosure of my information.

### **INSURANCE INFORMATION**

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

### **CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION**

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care or any clinic services that he/she deems necessary in my case; and further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patients' employer.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_