EXPRESS CHIROPRACTIC, LLC

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting our privacy. While the law requires us to give disclosure, please understand that we have, and always will, respect the privacy of our health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment or your health condition(s).

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or closed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to contact us at any time for a copy of our privacy notices.

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 or 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 to 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 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 insurances, the insurance company may have a right to your health information if they decided to contest any of your claims.

I have read your consent policy and agree to its terms in full. I am also acknowledging that I have received a copy of this notice.

_____	_____	_____
Patient Printed Name	Signature	Date
_____	_____	_____
Authorized Provider Rep.	Signature	Date

CASH ONLY VISITS

Each patient will be paying cash for services rendered. The full price for services performed such as adjustments and therapies will be due on the day of service or in advance. Patients must pay be cash, check or credit card. Any special payment arrangements must be approved by office staff for extenuating circumstances.

Being that some services may be reimbursed to you by your health insurance carrier, we can provide you with an itemized bill that you may then present to them. However, it is solely your responsibility to seek such compensations.

_____	_____	_____
Patient Printed Name	Signature	Date