

Disclosures and Consents

Version 4 – 1.15.18

Patient Name:	Date of Birth:		
Patient Authorization for Use a	nd Disclosure of Protected Health Info	ormation	
At times it can be convenient to allow another person, reports, medical records, bills and payment records wit to discuss anything about your health care, health need could also be a patient. To enable someone (or multiple may sign below.	th our office, etc.). Without a signed authorization is, treatment, or account balances with any person, or	n place, we are unable even your spouse who	
By signing, I hereby authorize Eriksen Chiropractic Ce it has (medical records, account records, x-ray reports,	¥ ¥	cted health information	
<u>Name</u> :	Relationship:		
The authorization will expire on: Indefinitely (until a	notified in writing) or \square Specific date of expiration		
415 Cardinal Drive, Elizabethtown, KY 42701 taken an action in reliance on the use or disclosure.	rsuant to this authorization may be redisclosed by the	ysician's practice has	
Printed Name:	Signature	Date	
If signed by anyone other than the patient, pleas	se write a description of the signer's authority to ac	ct for the patient:	
Comm	unication Preferences:		
Please select one from each category that apply: Work Phone:	Written Communication:		
☐ It is okay to leave a detailed message ☐ Please just leave a call back number ☐ Please do not call me at work if possible	☐ It is okay to mail detailed information☐ Please only mail statements and bill	· · · · · · · · · · · · · · · · · · ·	
Cell Phone: It is okay to leave a detailed message Please only send appointment reminders I do not have a cell phone.	Home phone: It is okay to leave a detailed messag Please just leave a call back number Please do not call me at home if pos I do not have a landline at home	r	
Email: It is okay to leave a detailed message Please only send appointment reminders I do not use email			



Disclosures and Consents, Page 2

Consent to treatment:

Chiropractic Centers	t for treatment for myself, or the	e named minor child, by the d	octors and staff of Eriksen
Printed Name:	Signature	Date	Relationship to patient
	<u>Financial R</u>	esponsibility Statement	
•		_	or treatment being successful. The financial aspect of treatment at our
<u>Insurance</u>			
the time of service. Ye to that contract. Please patient's benefits. We amount we expect you services rendered are company has indicated indicated they believe insurance company part of the property of the company part of the	Your insurance policy is a contra- se be advised that insurance con- e do our best to discover what be but will owe out-of-pocket in the aultimately the financial respon- ed they will cover and regardles the insurance company will cover prior to incurring charges at our	npanies often provide us with enefits your insurance provid form of co-pays, co-insurance sibility of the patient to pay re s of what Eriksen Chiropractic. We encourage you to verify offices.	ic Centers and its employees have your own benefits with your
<u> </u>	o being released by your doctor	<u> </u>	· ·
am fully responsible deductibles. Account addition, should my	for any unpaid account balance	s including, but not limited to may be subject to a finance or referred to a collection agence	•
I ha	ve read the Financial Policy. I	understand and agree to th	is Financial Policy.
Printed Name:	Signature	Date	Relationship to patient
	HIPAA Not	ice of Privacy Practices	
•			iven by:iven by:in the office whenever I wish or request