Sussex Chiropractic and Wellness Center
www.sussexchiropractic.com ♦ N63 W23524 Silver Spring Drive, Suite 4 ♦ Phone: (262) 246 – 8811
Sussex, WI 53089

Health Information Consent

Patient Name _____ Date of Birth: _____
Please Print (First, MI, Last)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning that information. As such, we require you to read, initial where indicated, and sign this consent form stating that you understand and agree with how your information will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPPA NOTICE available to you at the front desk before signing this consent.

_____ (initial) I understand and agree to allow this chiropractic office to use my PHI for the purpose of treatment, payment, healthcare operations, and coordination of care; for example:

- I agree to allow this office to submit requested PHI to the Health Insurance Company (or companies) I provided for the purpose of payment. I acknowledge that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- I also give permission for this office to discuss:

My **A**ppointment scheduling with: _____
(print name of individual) (relationship to you)

_____

My **B**illing information with: _____

_____

My **C**linical/Healthcare info with: _____

_____

_____ (initial) I understand I have a right to examine and obtain a copy of my health records any time and request corrections.

_____ (initial) I understand I may request to know what disclosures have been made and can submit in writing any further restrictions on the use of my PHI. The office is not obligated to agree to those restrictions.

_____ (initial) I understand that I only need to consent in writing one time for all subsequent care given to me as a patient in this office.

_____ (initial) I understand that I may provide a written request to revoke consent at any time during care. This would not affect the use of PHI or information in the patient record given prior to the written request, but would apply to any care given after the request has been presented.

_____ (initial) I understand that for my security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce the procedures in this office. This office has taken all precautions known to assure my PHI and health records are not readily available to those who do not need them.

_____ (initial) I understand that I have the right to file a formal complaint with this office's privacy official about any possible violations of these policies and procedures.

_____ (initial) I understand if I refuse to sign this consent for the purpose of treatment, payment and healthcare operations, this office has the right to refuse to provide care.

Do we have your permission to thank the person that referred you to our office? □ Yes □ No
Do we have your permission to put your name on the referral board when you refer someone? □ Yes □ No

By signing this consent, I acknowledge that I have read and understand how my PHI and patient records will be used, and agree to the policies and procedures adhered to in this office pertaining to Patient Health Information.

_____ _____
Signature of Patient / Parent or Guardian *Date*

(rev 6/2015)