IORITY LIFE
CHIROPRACTIC & MASSAGE
3401 SE 192nd Ave., #107, Vancouver, WA 98683
Phone: (360) 882-7733 Fax: (360-254-6821

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA)

Before we begin any health care operations, we require you to read and sign this consent form stating that you understand and agree with how your records will and can be used.

1. The patient understands and agrees to allow our chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance requires for payment. **Initial_____**
2. The patient has the right to examine and obtain a copy of his or her health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. **Initial_____**
3. A patient's consent need only be obtained one time for all subsequent care given to the patient in this office. **Initial_____**
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request, but would apply to any care given after the request has been presented. **Initial_____**
5. For your security and right to privacy, all staff has been trained in the area of patient confidentiality and record privacy. We have taken all the precautions that are known by this office to assure that your records are not readily available to those who do not need them. **Initial_____**
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures. **Initial_____**
7. If the patient refuses to sign the consent for the purpose of treatment, payment and health care operations, the attending chiropractic physician has the right to refuse to give care. **Initial_____**

MASSAGE CANCELLATION POLICY

Due to the limited availability in the massage therapy schedule, we have certain rules about unexcused absences.

- If you are unable to make your appointment please call at least 24 hours in advance. Doing so will ensure that we can fill the appointment for another patient. Failing to cancel an appointment **within 24 hours may result in a $20 non-refundable charge**. Emergency absences are accepted on a case by case basis. Three missed (unexcused) appointments will require you to pay for your massage at the time you make your appointment.

Initial_____

INSURANCE BENEFIT POLICY

As a courtesy, our office can call your insurance company to receive a quote of benefits on your behalf. We make every effort possible to give accurate information when quoting patient insurance benefits. Patient understands that verification of chiropractic and massage coverage is a **quote of benefits and NOT a guarantee of payment by the insurance company.** The patient accepts financial responsibility for any balance due, including those determined not covered under plan benefits. Any denial of payment becomes the patient's responsibility.

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INFORMED CONSENT POLICY

I hereby request and consent to the performance of massage therapy and/or chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) performed by licensed massage therapists and/or doctors of chiropractic who now or in the future work at the clinic or office listed above.

I have had an opportunity to discuss with a doctor of chiropractic, licensed massage therapist and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its' content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial_____

Your signature confirms your agreement to all four of the above policies.

Signature: _____ Date: _____

Patient's Name (Printed): _____

FOR MINORS (Under age 18):

Patient's Name (Printed): _____

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Name (Printed): _____