Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and you understand that…

You may be contacted by: phone, at home or work, mobile phone, e-mail or letter.
Messages may be left for you: on answering machine/voicemail at home, work and on mobile phone or with individuals answering your phone at home or work.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone having access to the reminder or information and may no longer be protected by the federal privacy rules. You may restrict the individuals or organizations to which your health care information is released or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

I authorize the use or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years form the date I last received services in this office.

Patient (or Personal representative) Signature _____ Date _____

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the Notice of Privacy Practices for protected Health Information of Martone Chiropractic Wellness Center.

Patient (or Personal representative) Signature _____ Date _____

Authorization to Utilize Testimonial

Seeing our patients enjoy good health is our primary goal. Many patients have let us know the improvements they've experienced in their overall health and well being since starting Chiropractic care. If you enjoy better health, we'd love to know and let others have the opportunity to be encouraged by your success. I, the undersigned, give permission to Martone Chiropractic Wellness Center to utilize my name, picture and testimonial to help educate others about the benefits of Chiropractic care. My name, picture and testimonial may be reproduced in any part or in full as an aid to understanding the science of Chiropractic care.

Patient (or Personal representative) Signature _____ Date _____

Authorization to Release and Pay Benefits Direct

I hereby authorize and direct my insurance carrier to pay all benefits, which may be due me according to my policy, directly to Martone Chiropractic Wellness Center, to be applied towards my account. I am also aware that I will be responsible for paying any balance on my account, including co-pays, co-insurance, deductibles, and for any non-covered services. I also authorize Martone Chiropractic Wellness Center to furnish information to my insurance company regarding my care and treatment in a manner consistent with the privacy policies of this office in obtaining payment for services provided.

Patient (or Personal representative) Signature _____ Date _____

Personal representative – Printed _____ Description of personal representative's authority to act for the patient. _____

Authorized Provider Representative (Office) _____ Date (Office) _____

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CHIROPRACTIC WELLNESS CENTERS