Patient Consent

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CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to Foothills Chiropractic to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 970-493-8360. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant you request. However, if we do decide to grant you request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and / of Title XI of the Social Security Act is correct. I authorize any holder of medical of other information about me, to release to the Social Security Administration or its intermediary carriers, and information needed for this or related Medicare claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____________.

*X*____
Print Patient's Name

*X*____
Patient's Signature

*X*____
Other Than Patient, Print Name & Relationship

*X*____
Witness
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NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information with out authorizations is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Your practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name_______________________________________ ***Phone***__________________

The effective date of this Notice of Information Practice is ____________________

Thank you,
Dr. James M. Haas D.C. & Staff

James M. Haas, D.C.

FOOTHILLS CHIROPRACTIC & SPORTS INJURY CLINIC

"PROVIDING MODERN TECHNOLOGY WITH OLD FASHION CONCERN"

MEMBER:
Colorado Chiropractic Assoc.
Am. Chiropractic Assoc.
International College of
Applied Kinesiology
Nat'l Board of
Chiropractic Examiners
Int'l Chiropractic
Honor Society
ACA Councils On:
Sports Injuries
Neurology
Diagnosis and Internal
Disorders

ADVANCED TREATMENT FOR:
Sports Injuries
Headaches
Neck Pain
Auto Accident
Injuries
Low Back Pain
Nutrition
Work Injuries

FOR YOUR COMFORT AND CONVENIENCE:
24 Hour Emergency Care
Insurance Accepted
Payment Options
Available
Evening and Weekend
Appointments

Dear Patient:

We try to make sure that every patient has a valid referral and/or authorization for the services he/she receives in our office. However, sometimes services are provided without us realizing that the referral has expired or proper authorization wasn't obtained. Some insurance companies have a policy to deny payment of these services. We encourage you to monitor your insurance coverage along with us, to achieve optimum benefits under your policy. We ask all patients who need authorizations or referrals to sign this waiver releasing our office from financial responsibility in the event that a claim is denied payment by your insurance company.

I agree to be responsible for all costs associated with health care services provided today, or in the future, to me by Dr. James M. Haas, should my insurance deny payment for any reason.

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NAME OF PATIENT (PLEASE PRINT) DATE

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN

1337 East Prospect Road
Fort Collins, Colorado 80525

(970) 493-8360
Fort Collins Club Office Park