Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **James M. Elliott, D.C. Practice of Chiropractic** "Notice of Privacy Practices" can be provided to me, upon my request.

I understand I have a right to review **James M. Elliott, D.C. Practice of Chiropractic** "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **James M. Elliott, D.C. Practice of Chiropractic.** This "Notice of Privacy Practices" also describes my rights and **James M. Elliott, D.C. Practice of Chiropractic's** duties with respect to my protected health information.

James M. Elliott, D.C. Practice of Chiropractic reserves the right to change the privacy practices that are describes in the "Notice of Privacy Practices". I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Patient Name (please print) **Date**

_____

Signature of Patient
(OR Parent or Legal Guardian if under 18 years)

_____

Please list person(s) who have permission to access your medical records

Do you want your insurance company billed today? _____ No _____ Yes*

If yes, please read and initial below:

Note:

Checking eligibility and/or benefit information is not a guarantee of payment from your insurance. We will do our best to inform you of what your financial commitment will be. Your claims will be billed to your insurance company for processing. Once they have processed the claims they will send us and you, an Explanation Of Benefits detailing their coverage and your financial responsibility for each claim. Amounts processed to deductible, co-pays, and denied claims will be your responsibility _____Initial