134 E. Main St. Ste. A ✷ Stockbridge, MI ✷ 49295 ✷ 517-851-3850

Positively Chiropractic's
TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation*:* A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. If you desire advice, diagnosis, or treatment for abnormal findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the body. Our only treatment is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of Positively Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure that is advisable and necessary for my health care.
I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.
I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.
It is office policy at Positively Chiropractic for a payment method to be kept on file. This ensures timely and efficient payment options to be rendered through Positively Chiropractic. This information is kept strictly confidential.

HEALTH CARE AUTHORIZATION

I have been provided with a copy of the Notice of Privacy Practice for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. Thereby give permission to Positively Chiropractic (PC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to PC to use my address. Phone number and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If PC contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to PC to use my name on a welcome board, referral board, and birthday board.
- I give permission to PC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to PC to use any testimonial written by me for marketing purposes such as sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give PC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. *Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations per request.*

By signing this form you are giving PC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Positively Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.
You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of PC.

The written notice must contain the following information:
Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request and Your signature.

The revocation is not effective until it is received by the Privacy Official.
This AUTHORIZATION is requested by PC for its own use/disclosure of PHI (Minimum necessary standards apply).

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, PC will not refuse to provide treatment however, it will not be possible for PC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since PC will be unable to contact me 3) all contact with PC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for care or by mail. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURE

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to five 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.

I have read this consent policy and agree to its terms. I am also acknowledging that I have received a copy of this form.

Printed Name _____Date _____

Signature_____

Authorized Provider Representation _____Date_____