We Care Chiropractic Center

Helping to improve your quality of life since 1985!

PATIENT CONFIDENTIALITY FORM

Name:______________________ Date of Birth: __/__/____

Under national HIPAA guidelines, we many not release ANY information about your healthcare (ie, appointments, condition/diagnosis, studies and/or results and treatment plan) without direct authorization from you (except for payment purposes with your insurance company or by court order).

PLEASE PLACE YOUR INITIALS NEXT TO ACCEPTED AREAS, LEAVE UNACCEPTED AREAS BLANK

___List the family members whom we may inform/discuss about your general medical condition and diagnosis.

___List the family members whom we may inform/discuss about your medical condition ONLY IN CASE OF EMERGENCY.

___List the family members or other persons who are authorized to pick up on you behalf, healthcare information such as medical records, test results, etc. (any persons not mentioned here may not pick up information).

___I authorize We Care Chiropractic to leave messages regarding appointments and products that were ordered only on my answering machine/voicemail of the number provided.

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination and treatment.

I hereby assign, transfer and set over to We Care Chiropractic Center, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. The authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges, whether or not they are by covered by insurance.

Signature_______________________ Date:__/__/____