

Maloney Chiropractic PLLC
Dr. Kevin Maloney, D.C.
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Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of the treatment, payment, or health care operations. Use of disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may request this consent to the use and disclosure of your PHI. You must revoke the consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have received the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: X _____ Date _____

Assignment of Benefits

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of service provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date at which it was filed. In the event that your insurance does not pay in a timely manner, you may be asked to contact your insurance carrier.

Patient or Parent Signature: X _____ Date _____

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risk of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of Maloney Chiropractic PLLC to treat said child.

I hereby acknowledge that if I do not keep my appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within reasonable period of time. I understand that failure to complete my recommended plan may jeopardize my case.

Patient or Parent Signature: X _____ Date _____