

**CHOICE OF HEALTH P.A.
DR. RICHARD SNOW
9163 W 133RD STREET OVERLAND PARK, KANSAS 66213**

**Notices of Privacy Practices
HIPAA**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws on 9/23/2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Obtain payment from third-party payers. *Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinics charge including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, orthopedic and neurological evaluation, visual inspection, palpation, X-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case. The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, activator, joint mobilization, myofascial release, trigger-point therapy, electrical therapy, intersegmental traction, muscle stretching, and any directional handouts. Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint. Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risks must be recognized and considered. Any procedure that is intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness or weakness. A patient, in coming to Choice of Health, P.A., gives Dr. Richard Snow (*the doctor*) permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of Dr. Richard Snow. The doctor provides a specialized, non-duplicating health care service. Dr. Richard Snow is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Choice of Health, P.A., I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately. If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion. I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

I declare that, to the best of my knowledge, (I am not pregnant, my child is not pregnant), nor are there any known complicating limitations which would forbid taking x-rays. I understand that in the event x-rays are taken, that they will be referred to RADIOLOGY DIAGNOSTICS for a second opinion for further interpretation and give consent for their release. I understand that there will be a fee for this service of \$70.00.

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that I may be contacted by: phone at home or work, mobile phone, e-mail, text, or postcard. Messages may be left: on answering machine/voicemail at home, work, a mobile phone and/or with individuals answering my phone at home, or work.

Clinical Summary Report (CCR) regarding EHR

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Choice of Health, P.A. to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

Assignment of Benefits

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Choice of Health P.A. will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Choice of Health P.A. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Print Patient Name: _____ **Authorized Signature:** _____

Relationship to patient (if not self) _____ Date: _____