Camp County Clinic of Chiropractic & Rehab

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Patient Consent Authorization & Privacy Practices

Consent for treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out instructions of such physician(s).

Assignment of benefits: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not exceed the physician's regular charges. I understand that I am not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

Release of information: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician or to the patient or to a family member or employer of the patient for all part or part of the physician's charges. Including but not limited to, insurance companies, worker's compensation carriers, welfare funds, attorney, or the patient's employer.

HMO Disclaimer: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO) subsequent rejection of a claim as a result of this admission due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part.

Medicare and Medicaid patient certification – patient certification authorization to release information and payment request: I certify that the information given by me in applying for payment under the Title XVIII and for the Title XI of the social security act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare and Medicaid claims. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for the physician(s) services. I understand that I am responsible for my health insurance deductible and coinsurance.

Verification of non-pregnancy (female patients only): By my signature on this form I do herby state to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Date of last menstrual period: _____

Consent for treatment of a minor child if applicable: I hereby authorize the clinical and ancillary staff for Camp County Clinic of Chiropractic & Rehab to administer treatment as they so deem necessary to my_____, _____
(Son, Daughter, etc.) (Name of Minor)

_____

Print Patient's Name Date

_____

Patient's Signature/Guardian if patient is a minor Relationship to Patient

_____

Witness