

Sjogren Chiropractic Center Inc.

113½Main St.
Oxford, MA 01540
P(508) 499-3919, F(508) 499-3726

Patient _____

Pt. File # _____

Date _____

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 you understand that...

You may be contacted by: phone at home or work, mobile phone, e-mail, or postcard.
Messages may be left for you: on answering machine/voicemail at home, work, and on mobile phone.
Or with individuals answering my phone at home, or work.

(Please place a line through any method that you refuse to be contacted by and initial.)

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone having access to the reminder or information and may no longer be protected by the federal privacy rules. You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give 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. You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

Patient (or Personal representative) Signature

Date

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the *Notice of Privacy Practices for Protected Health Information* of Sjogren Chiropractic Center Inc.

Patient (or Personal representative) Signature

Date

Authorization to Release and Pay Benefits Direct

I hereby authorize and direct my insurance carrier to pay all benefits, which may be due me according to my policy, directly to Sjogren Chiropractic Center Inc. to be applied towards my account. I am also aware that I will be responsible for paying any balance on my account, including co-pays, co-insurance, deductibles, and for any non-covered services. I also authorize Sjogren Chiropractic Center Inc. to furnish information to my insurance company regarding my care and treatment in a manner consistent with the privacy policies of this office in obtaining payment for services provided.

Patient (or Personal representative) Signature

Date

Personal representative – Printed

Description of personal representative's authority to act for the patient.

Authorized Provider Representative:

Date: _____ witnessing signing of: ARHCIA PNA ARPBD