

## Consent For Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

### We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of you health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the "NOTICE OF PRIVACY PRACTICES" binder in reception or ask for a copy at the Front desk.

\_\_\_\_\_  
Name (Printed please)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party:

\_\_\_\_\_  
Personal Representative (Printed)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Date

Wink Chiropractic Wellness Center

phone 920/921-4130

fax 920/921-4331

924 Forest Avenue

Fond du Lac, WI 54935

[www.winkchiro.com](http://www.winkchiro.com)

## INFORMED CONSENT FOR TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic, physical therapy, and/or diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for Wink Chiropractic Wellness Center, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of any medical, chiropractic, and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

### TO BE COMPLETED BY PATIENT

Patient's Name \_\_\_\_\_ Signature of Patient \_\_\_\_\_  
(PLEASE PRINT)

Date Signed \_\_\_\_\_ Witness or Patient's Signature \_\_\_\_\_

### TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name \_\_\_\_\_ Signature of Patient \_\_\_\_\_  
(PLEASE PRINT)

Date Signed \_\_\_\_\_ Signature of Representative \_\_\_\_\_

Relationship or Authority of Patient's Representative \_\_\_\_\_

### TO BE COMPLETED BY DOCTOR OR STAFF

Name of Doctors treating this patient:

1. \_\_\_\_\_ PIN# \_\_\_\_\_  
(PLEASE PRINT)

2. \_\_\_\_\_ PIN# \_\_\_\_\_  
(PLEASE PRINT)

3. \_\_\_\_\_ PIN# \_\_\_\_\_  
(PLEASE PRINT)