KIM CHIROPRACTIC CLINIC, P.A.

462 W. Central Parkway
Altamonte Springs, FL 32714
(407)788-9955

NOTICE OF PRIVACY PRACTICES

Dear Patient:

The United States Department of Health has ruled that effective April 14, 2003, HIPAA (Health Information Portability & Accountability Act) will mandate new guidelines for all healthcare provider offices, including ours, to follow. This law is designed to protect all patients against the release of confidential information without their authorization.

Consequently, we are instituting some policy changes to ensure that we are in compliance with the law. Henceforth, we cannot legally discuss any of your personal information (medical or billing information) with anyone (your spouse, parents, children, etc.) unless we receive your *written* authorization. Also, in accordance with the law, you must instruct us, *in writing*, how you would like us to contact you regarding future appointments, test results, follow up appointments, etc. if you do not want us to call you at the telephone numbers provided to us on your initial registration form.

HIPAA is designed to protect your privacy. Although, in the past, we have used ethics and common sense to do so, we are now required by law to adhere to a policy, which will guarantee it. If you would like a copy of our Notice of Privacy Practices, please be sure to ask our front office staff. This information is available to you upon request. We regret any inconvenience this may cause you. If you should have any questions or concerns, please do not hesitate to contact our office for assistance.

I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (Please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

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INFORMED CONSENT FOR CHIROPRACTIC CARE
ASSIGNMENT OF BENEFITS
RESPONSIBILITY OF PAYMENT

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Kim Chiropractic Clinic P.A.

I have had the opportunity to discuss with the doctor and/or other office or clinical personnel the purpose and benefits of chiropractic adjustments and other treatments provided by Kim Chiropractic Clinic P.A.

I hereby accept the responsibility of payment for all treatments provided to me (or to the patient named below, for whom I am legally responsible) by Kim Chiropractic Clinic P.A. If you have insurance coverage, I assign directly to Kim Chiropractic Clinic P.A., all insurance benefits and I understand that I am financially responsible for all charges that are not paid by insurance.

I understand that Chiropractic care requires my co-operation, and I will follow my doctor's orders. If indicated I will make and keep appointments for follow up care and call the office to note any changes or concerns.

Date: _____

Patient Name: _____

Signature of Patient: _____

Signature of Parent/Guardian: _____