Discovery Chiropractic
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DiscoveryMN.com
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CONSENT TO ARRANGE FOR PAYMENT AND SHARING OF MY INFORMATION (HIPAA)

Patient Name:_____ Date _____

Initials: _____ My consent for sharing (release) of my information

- **For treatment**: I authorize you, as my provider, to share my information with other healthcare professionals and facilities for treatment purposes, such as managing or coordinating my care, and related services.
- **For payment:** I authorize you, as my provider, to share my information with my health plan and others as needed for payment purposes, such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, utilization review, and related functions, including those functions that you, as my provider, are required by my health plan or other third-party payers to perform.
- **To run your organization (health care operations):** I authorize you, as my provider, to share my information with others to improve the quality of my care and experience, and to manage your business operations. This includes activities such as licensing, accreditation, and evaluating quality.
- **Health plan information:** I authorize my health plans to share my information (about services I have received) with you, as my provider, and with other professionals and facilities from whom I receive healthcare, as needed for treatment, management and coordination of my care, accreditation and quality review/measurement.

Initials: _____ My responsibility for payment and assignment of benefits.

- **I authorize you**, as my provider, to bill my health plans (including Medicare/Medicaid and other third-party payers), directly on my behalf, so that you will receive direct payment of authorized benefits.
- **I agree** that it is my responsibility to pay for any items or services not covered by my health plans, such as co-payments, deductibles or co-insurance.

Initials: _____ Electronic Communications

I authorize Discovery Chiropractic and its employees, contractors or Doctor of Chiropractic to contact and communicate with me through electronic communications. This includes but not limited to text messaging, digital phone calls and social media (Facebook, Messenger, WhatApp, etc.).

My signature and acknowledgment

My consent will be valid for ten years from the date I give it. I may revoke my consent to share my information, in writing, at any time. Revoking my consent doesn't apply to information that has already been shared. I understand that some uses and sharing of my information are authorized by law and do not require my consent.

Provider's Notice of Privacy Practices has been made available to me. It describes my privacy rights and additional disclosures my provider may make according to law.

_____
Signature of Patient

_____
Print name

_____
If authorized representative, relationship to patient