

Dr. Brandon January, January Chiropractic and Acupuncture PLLC
Consent, Assignment, and Agreement

Health care operations require you must read and sign this consent form stating you understand our office policies and how your records are handled. If you need a more detailed description of the privacy of your PATIENT HEALTH INFORMATION, our HIPPA NOTICE is available upon request from office staff.

1. I certify that all the information given in the provided intake questions and information is true and correct to the best of my knowledge. I give my consent to Dr. Brandon January the render treatments to myself/child as deemed necessary by the attending physician. I understand that I have the right to refuse such services at any time, and will be informed of any changes in treatment prior to their performance. By signing the form and once treatment is accepted, informed consent has been satisfied. A patient's written consent need only be obtained one time for subsequent care given to the patient in this office.
2. I understand that I am fully responsible for the payment of services rendered. I further understand that health and accident insurance policies are an arrangement between the carrier, and me and that I may be required to pay some or all of the fees charged because of services provided. I hereby assign benefits to be paid directly to the office of Dr. Brandon January by my third-party payer (I.e., insurance company, attorney, etc.). My signature below shows agreement that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between me and the office of Dr. Brandon January. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest of 18% APR, which is the patient's responsibility for services past rendered. Payment for services rendered at due at completion of these services, unless prior written arrangement is agreed upon.
3. I give my consent to the office of Dr. Brandon January to perform x-rays as deemed necessary by the attending physician. I declare that to the best of my knowledge, (I am not pregnant, my child is not pregnant), nor are there any known complicating limitations which would forbid receiving x-rays.
4. I authorize the office of Dr. Brandon January to send me e-mail, metered mail, phone texts and any other communication that is carried on to inform and notify of office hours and sudden changes in schedule.
5. The patient has the right to examine and obtain a 1-time copy of his or her own health records at any time and request corrections. A fee of 25\$ will be charged and paid in advance by the patient for forms needed to be filled out by the Doctor that fall outside the normal record keeping of this office. (I.e., AFLAC, Disability, Social Security, FMLA). The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to these restrictions.
6. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been presented.
7. HIPPA -for your securing right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to ensure these procedures are in place and current. We strive to ensure that your records are not readily available to those who request, want or do not need them. Patients have the right to file a complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment of healthcare operations, the chiropractic office has the right to refrain from delivering care in which there is no understanding in which the services are to be delivered.
9. Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking the office of Dr. Brandon January to save these electronically for me and not print them out at each visit. I understand that upon request that these reports are available to be printed or e-mailed for me to review.

I have read and understand how my Patient Health Information will be used, understand informed consent and HIPPA, and agree to these policies and procedures.

Name of Patient: _____

Date: _____

Patient/Guardian: _____