Advanced Spine and Health Center Patient Name: _____ Date: _____
Dr. Thomas Fullmer D.C.

HIPPA NOTICE OF PRIVACY PRACTICES & INFORMED CONSENT TO TREAT

This notice of privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or health care operations for purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physicians' practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your health care information may also be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.
In the event that a new physician should join or take over Advanced Spine & Health Center, your protected health information will be provided to the new physician for the purpose of continuing your health care treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations are included as required by law; public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. We must make disclosures to you when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164_500.
OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.
You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Informed Consent to treat: I hereby request and consent to the performance of chiropractic procedure, including various modes of physical therapy/physiotherapy, diagnostic x-rays and any supportive therapies on me (or the patient named above, for whom I am legally responsible) by the doctor of chiropractic indicated and/or other licensed doctors and support staff who now , or in the future, treat me while employed by, working or associated with, or serving as back up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatments are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It may also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all health care treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to; muscle spasms for short periods of time, aggravated and/or temporary increase in symptoms, lack of improvement of symptoms, burns from ice or heating devices, 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 procedures which the doctor feels at the time, based upon the facts then known, are in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. Those treatment options include, but are not limited to; self-administered, over the counter analgesics and rest, medical care with prescription drugs, such as anti-inflammatory drugs, muscle relaxants and pain killers, physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and to seek other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, pro-rated fees for unused prepaid treatments will be refunded if I wish to cancel the treatment.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Signature of Patient or Representative Date