Millner Family Chiropractic 117 3rd Street Hastings, MN 55033 651-437-1876

Notice of Privacy Practices, Acknowledgement & Consent

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Hauck Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patients Name: _____ Date: _____
Patient's Signature: _____ Time: _____
Authorization for Minor: _____ Date: _____
Witness Signature: _____ Date: _____

CONSENT FOR THE TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date: _____ Time: _____ AM/PM

I have been informed by Dr. Millner that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problems (or illness).

I authorize Dr. Millner to perform such radiographic examination necessary to diagnose, and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Patient's Signature: _____ Date: _____
Authorization for Minor: _____Date: _____
Witness Signature: _____ Date: _____

To the best of my knowledge I am NOT pregnant and the above named doctor has my permission to x-ray me for diagnostic interpretation.

Patient's Signature: _____ Date: _____

FINANCIAL POLICIES:

Payment is expected the day of service.

It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. It is understood that at any time during or after my care, my insurance may deny coverage (this includes denial after initially stating the rendered services were covered).

Patient's Signature: _____ Date: _____