

## Acknowledgements

Patient Name \_\_\_\_\_

FILE # \_\_\_\_\_

DATE \_\_\_\_\_

### Acknowledgement of Receipt of "HIPAA Notice of Privacy Practices"s

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Healing Touch Chiropractic, Petros, Cherra & Pirnia Corporation (HTC) and the Practice's policies and procedure regarding the use and disclose of any of my protected health information created, received or maintained by HTC. In addition, I authorize HTC to communicate protected health information through the use of mail, phone, voicemail, E-mail, and personal communication. This may include electronic communication such as announcements or appointment reminders via text message.

Patient or guardian Initials \_\_\_\_\_

### Assignment of Benefits & Release of Health Information

I Authorize Healing Touch Chiropractic to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, replying to requests from my insurance company, evaluating the quality of services provide, communicating with my referring physician, and any other administrative operations related to treatment or payment as noted in HTC's Notice of Privacy Practices. I understand that benefits quoted from my insurance carrier to Healing Touch Chiropractic are only an estimate and not a guarantee of payment. I assign HTC all benefits payable to me under my insurance policies and health benefit plans. I shall be personally responsible for any unpaid balances.

Patient or guardian Initials \_\_\_\_\_

### Agreement in financial responsibility

I understand that I am directly and fully responsible to for all medical charges resulting from any consultation examination and/or treatment which I will receive. I am aware that this agreement is made solely for the doctor's protection and in consideration of any awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

Patient or guardian Initials \_\_\_\_\_

## Notice of Financial Interest

California Law and federal Medicare regulations require physicians and other health care providers to make certain disclosures to Patients when they refer a patient to a facility in which the physician or physicians' direct family member may have financial interest. We support these laws in order to help patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of these laws, you are being advised that, although this facility does not have any direct financial interest in the facility we may refer; your physician's or a shareholder's family member may have a financial interest at the health care facility referred.

The law requires your acknowledgement that you have read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file.

### Acknowledgement

I have read this "Notice of Financial Interest" form, and I understand by signing this form that Healing Touch Chiropractic, Petros, Cherra & Pirnia Corporation has disclosed any direct or indirect financial interest in the facility referred.

Patient or guardian Initials \_\_\_\_\_

\_\_\_\_\_  
PATIENT OR GUARDIAN SIGNATURE\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE