Wilkinson Clinic of Chiropractic
115 E Waverly St
Morris, Il 60450
P815-942-5350 F815-942-5414
www.drphilwilkinson.com

Patient Acknowledgements

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been offered to me prior to my signing this Consent, and is readily available both in the clinic and if I ask. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice.
3. The practices "NOPP" is provided at the clinic, may also request a copy via fax, email, or mail.
4. The "NOPP" also describes my rights and the duties of this office with respect to my PHI.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. _____INITIAL

RELEASE OF INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, adjuster or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your health care facility _____ INITIAL

RIGHT TO RECEIVE PAYMENT

I authorize and sign to you, Dr. Wilkinson, to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay me any sums. I further authorize endorsements of my name to any draft containing my name to which you are legally entitled. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring full payment to our office immediately upon receipt. _____ INITIAL

VOLUNTARY TERMINATION OF CARE

I understand that if I suspend or terminate my care at any time, prior to Dr Wilkinson's recommended care, that my portion of all charges for professional services are immediately due and payable to Dr Wilkinson. All services performed by Dr Wilkinson will be directly charged to me, and ultimately I will be responsible for payment regardless of insurance coverage. _____INITIAL

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____ _____
Signature of Legal Representative Date Signed Relationship