

Minor: Consent for Treatment

I grant Watertown Chiropractic, P.C. and other healthcare staff permission to provide chiropractic treatment for my child. I further give permission to Watertown Chiropractic, P.C. and staff to contact my child's primary healthcare provider regarding past medical history, if necessary.

Child's Name: _____ Date: _____

Parent's Name: _____ Date: _____

HIPAA: Notice of Privacy Practices for Protected Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Here are some examples of how we might have to use or disclose your health care provider. Our insurance and billing department may have to disclose examination and treatment records to another party; such as, an insurance carrier, an HMO, a PPO, your employer or lawyer. The medical staff may have to use your information to call you regarding your appointment. Your information may be used for quality control purposes or other administrative purposes.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information, if you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization. We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices. However, we reserve the right to change the terms of our privacy notices.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Please Sign, Date and Sign For Claims: