hines HEALTH 305 N. 24th Street Rogers, AR 72756-3294

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT ME MAY BE USED AND DISCLOSED AND HOW I CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW CAREFULLY.

By signing this form, I am granting consent to Hines Health to use and disclose my Protected Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. The Notice of Privacy Practices provides more detailed information about how Hines Health may use and disclose this PHI. I have the legal right to review the Notice of Privacy Practices before I sign this consent. Hines Health encourages that I read it in full. A copy is available at the front desk, at hineshealth.com and posted in the reception area.

For purposes of this consent, PHI means any information, including demographic information that relates to my past, present or future physical or mental health condition. I may submit in writing any further restrictions on the use of my PHI. Hines Health is not required to agree to these restrictions, however if they do grant the request, they are bound by the agreement.

For my security and right to privacy, Hines Health staff has been trained in the area of patient record privacy. I have the right to file a formal complaint with the office about any possible violation of these policies and procedures.

I have the right to revoke this consent in writing, at any time, except to the extent that Hines Health has acted in reliance on this consent. The Notice of Privacy Practices is subject to change. A copy may be obtained by contacting Hines Health at (479) 636-3021.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT

I have requested chiropractic care from Hines Health on behalf of myself and/or my dependents and by making this request, I become financially responsible for any and all charges incurred in the course of the treatment authorized. Hines Health will accept assignment of insurance benefits, if applicable, but I am required to pay the estimated patient responsibility at the time of service. In the event that the estimated amount collected is found to be insufficient after review by my insurance company, I will be required to pay the balance in full.

I hereby assign all benefits to which I am entitled, if any, directly to Hines Health. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Hines Health for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance, regardless of their managed care network participation status. I hereby authorize the use of this signature on all insurance submissions for the period of lifetime, unless revoked by me in writing and that a photocopy of this assignment is considered as valid.

NO INSURANCE

I do not currently have any form of third party reimbursement insurance, either privately, through an employer or under Medicare. I further understand that Hines Health does not accept retroactive assignment of benefits for services previously rendered.

CANCELLATIONS / LATE ARRIVAL

I understand that Hines Health requires a 24 hour notification of cancellation of appointments so that they may offer the time to another patient. There is a $20.00 fee for missed appointments and is due before my next appointment. This charge is not covered by or billed to my insurance. If I am 10 minutes late or more, I may be rescheduled in order to accommodate other patient's appointments.

I have been given the opportunity to review Hines Health's Notice of Privacy Practices prior to signing these consents. I understand how my PHI will be used and I agree to these policies and procedures.

Print Name	Signature	Date

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