

**Touch of Life Family Wellness Center**  
**4214 Medical Parkway, Suite 201 Austin, Texas 78756**  
**P 512.458.9200 F 512.458.9300**

---

**Health Insurance Portability & Accountability Act (HIPAA) Consent Form**

**THIS NOTICE DESCRIBES HOW RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1) Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment of treatment. 2) Your health records as well as your billing records may be disclosed to another party, such as an insurance carrier (HMO, PPO, Auto, etc.) or the party responsible for payment. 3) Your name, address, phone number, and your health records may be used to contact you regarding appointment reminder, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account.

By signing below, I, \_\_\_\_\_ acknowledge that I have read the above information and give full disclosure of my information.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I understand and agree that health and/or accident insurance policies, including any third-party involved, are an agreement between that carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION**

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case. I further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, or insurance companies.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_