CONSENT FORM

Consent to Examination and Treatment

By signing below, I give the doctors and staff of Enlightened Chiropractic permission to perform all examinations, tests, treatments and anything else deemed necessary or beneficial to my care. I also understand that these actions will be performed by either the doctor or an assigned staff member of Enlightened Chiropractic. I further understand that all insurance payments made directly to this office will be credited to my account.

Consent to Retrieve Medical Records

By signing below, I give the doctors and staff of Enlightened Chiropractic permission to collect any and all medical records deemed necessary to assist with my care. This includes records from hospitals or any other provider of services which would be helpful in assisting in my case

Consent to Release of Medical Records

By signing below, I give the doctors and staff of Enlightened Chiropractic permission to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge. The includes, but is not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Consent to Receive Appointment Reminder by text message or email

I hereby give my consent to Enlightened Chiropractic to send text message/email reminders to my mobile telephone (as per the number and carrier I have listed). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to make an appointment for an adjustment. All patients have the right to stop this service. If you no longer wish to receive these text reminders please notify our office. If you change your mobile number please inform us to that we can update our records.

Request Health Records

The patient has the right to obtain a I time copy of his or her health records at any time. A fee of $25 will be charged and paid in advance by the patient for forms needed to be filled out by Dr. Nguyen that may fall outside the normal book keeping of this office. (I.e. AFLAC, FMLA, Disability, Social Security). The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of the PHI. Our office is not obligated to agree to these restrictions.

Verification of Non-Pregnancy (Women Only)

By my signature below, I do hereby state that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

Assignment and Conveyance of Lien Interest for Personal Injury Patients

(Motor Vehicle Accidents Only)

I hereby execute and provide an Irrevocable Lien interest and Assignment of proceeds to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance, policy to which I am entitled, and from which I am paid in the form of an insurance settlement(s), claim(s), judgments, or verdict(s) resulting from any identified accident. The insurance carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter

be paid directly to the above named doctor and or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney and I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment for all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s). The patient understands und agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest rate of 15% APR after 90 days from last date of service, which is the patient's responsibility for services past rendered. Payment for services rendered at due completion of these services, unless prior written arrangement is agreed upon.

Assignment of Benefits for Insurance Purposes

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance **DOES NOT** guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a daily basis as a courtesy to you. You will be responsible for your deductible and/or Co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours. The patient understands und agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest rate of 15% APR after 90 days from last date of service, which is the patient's responsibility for services past rendered. Payment for services rendered at due completion of these services, unless prior written arrangement is agreed upon.

Clinical Summary Report (CCR)

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Enlightened Chiropractic to save these electronically for me and not print them out after each visit. I understand that upon request these reports are available to be printed or emailed to me for review.

Notice of Privacy Policy: Effective September 16, 2013

By my signature below, I understand my HIPAA rights at Enlightened Chiropractic. Our office follows the privacy policy described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice. You can request a copy from the front desk.

Please read the above statements and sign below.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____