CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient- please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices as described in our Notice of Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes that may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office:

Address: 1101 E 7th ST. Atlantic, IA 50022
Telephone: 712-243-5790 Fax: 712-243-3975
E-Mail: midwesthealth@iowatelecom.net

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you, if you revoke this Consent.

I authorize Midwest Health Center, PC to contact me on my health condition to promote health services at Midwest Health Center, PC. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Consent for RX hub: I authorize Midwest Health Center, PC to electronically request my medication history, from all pharmacies and providers, in order to provide continuity of care for this and future visits.

Signature:____ **Date:**_________________________

INFORMED CONSENT FOR MEDICAL OR CHIROPRACTIC CARE

I hereby request and consent to the performance of medical or chiropractic care on me, or on the printed name below for whom I am legally responsible, by the Doctor, James B. Kickland or Family Nurse Practitioner, Haley D. Kickland of Midwest Health Center, PC who now or in the future may treat me. I have had an opportunity to discuss with the providers named and/or with other clinic personnel the nature and purpose of medical and chiropractic procedures.

I understand and am informed that, as in the practice of medicine, and in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

I authorize payment of medical benefits to Midwest Health Center, PC for any and all services provided.

Patient's Name:__________________________**Signature:**_________________________________

Date:____________________ **Parent/Guardian Signature:**_________________________________

WELCOME TO OUR OFFICE

IF NO INSURANCE: Payment is due when the services are rendered. We gladly accept cash, check, Debit Card, Visa, and MasterCard.

INSURANCE: Please pay your co-payment, co-insurance, or deductible at each visit. After we receive payment from your insurance company, we will bill you for any balance due or issue a refund in case of overpayment. Any procedures/supplies not covered by your insurance will have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable in full immediately regardless of any insurance claims submitted.

MEDICARE/MEDICAID: Medicare insurance covers 80% of the allowed charge for spinal adjustments done by the chiropractor after your annual deductible is met. Medicare **does not** cover x-rays taken by a chiropractor. X-rays are $70.00 and payment is due on the visit date they are taken. Medicaid covers chiropractic adjustments and x-rays. A $1 co-pay per visit may apply. Most medical services are covered by Medicare and Medicaid with a $3 co-pay when applicable.

INTEREST CHARGES: Interest will be charged to all delinquent accounts. Any cost to collect delinquent accounts will be your responsibility. Midwest Health Center, PC reserves the right to charge an additional fee for collection of delinquent accounts.

ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: I hereby authorize Midwest Health Center, PC to file my claims. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Midwest Health Center, PC. I convey a lien against any funds and authorize and direct any third party to withhold sum from any benefits, judgments, verdict, settlements, or recoveries and to adequately protect ant to make payment for these services directly to Midwest Health Center, PC pursuant to this assignment and lien.

ASSIGNMENT OF CAUSE OF ACTION: In the event that any insurance company or third party obligated to make payment to me or to Midwest Health Center, PC for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer and convey to Midwest Health Center, PC any and all cause of action that might exist in my favor against any such company or person. I authorize Midwest Health Center, PC to prosecute said action either in my name or their name to collect fees due for care rendered and legal expenses and to resolve said claims as they see fit. In the event that it becomes necessary to retain an attorney, I agree that I am responsible for all court costs and attorney fees.

AUTHORIZATION TO PROCESS DRAFTS: I AGREE THAT Midwest Health Center, PC shall be appointed as my agent to endorse drafts to sign my name on any checks for payment of my bill for medical or chiropractic services rendered.

VENUE: I agree that all charges are payable and collectable in Cass County and that all provisions of this contract are to be performed in Cass County. The invalidity or unenforceability of any provision hereof shall in no way affect the validity or enforceability of any other provision.

Signature:____**Date:**__________________________

Person responsible for account:__________________________________ **DOB:**__________________
Relationship (If other than Self):__________________________ **Social Security #:**________________
Address:______________________________________**City:**____________________**State:**________
Home Phone:______________________**Cell Phone:**______________________________________
Employer:_________________________**Address:**____
Work Phone:______________________**E-mail:**____