SMALL MIRACLES
NATURAL HEALTH CENTER
Chiropractic-Nutrition-Massage

BLANKET AUTHORIZATION / RELEASE FORM

_____ **Insurance Assignment** – I authorize payment of medical benefits from _____ Insurance Company to be paid directly to: Central Connecticut Chiropractic, P.C. or Michele Imossi, D.C., 36 Chamberlain Highway, Kensington, CT 06037 for services rendered to me. I also acknowledge that all services rendered to me are ultimately my financial responsibility. I agree to pay any balance that remains after my insurance company has made payment, for any non-covered items/services as listed by my insurance company and any unpaid balance that remains, 60 days after services are rendered.

_____ **Cash Policy** - I do not have in-network insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

_____ **Medicare Policy** – I understand that I am responsible for an examination fee, as well as fees for any x-rays that might be taken. Some Medicare advantage plans require a referral. If my claim is rejected by the insurance company because of no referral, I understand that I will pay the balance.

_____ **Records Release** – I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to Central Connecticut Chiropractic, P.C. This includes UCONN Health Center.

_____ **Authorize to Release Information** – I authorize your office to release any information you deem appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me in this chiropractic office. I hereby release you from any consequences thereof.

_____ **Pregnancy Release** – To the best of my knowledge, I am not pregnant. I understand that x-ray radiation may pose risks to an unborn child. I consent to having x-rays taken, and I release the staff of Central Connecticut Chiropractic, P.C. from any responsibility that could in any way associated damage to an unborn child with the x-ray examination.

_____ **Termination of Care Waiver** – I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending chiropractor, I cannot expect maximum chiropractic results and the doctor has full and complete right to terminate my case and discharge me from care.

_____ **Consent to Treat Minor** – I hereby give my consent for Michele Imossi, D.C. at Central Connecticut Chiropractic, P.C. to examine and render treatment to my child who is a minor.

I have read the above blanket authorization/release form and agree to the _____items checked off.

_____ Patient Name (print)

_____ Patient/Guardian Signature

Date:_____

Witness:_____

Dr. Michele Imossi, D.C. • 36 Chamberlain Highway, Berlin, CT 06037 • PH: (860) 828-3435 • FAX: (860) 828-1203

Central Connecticut Chiropractic, P.C. DBA:
Small Miracles Natural Health Center

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We take protecting your privacy very seriously. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. This also includes requesting records from previous health care providers or hospitals.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. This includes verification of your insurance coverage.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I have read your consent policy and agree to its terms. I also acknowledge that a copy of this notice is available to me upon request.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date

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