

## Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

**Ownership of X-ray Films:** It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

Guardian or spouse authorizing care signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

## Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict my personal information is used and or disclosed.

Patient Name (Please Print):

\_\_\_\_\_

Relationship to Patient:

\_\_\_\_\_

Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

## Photos and Video Permission

Platinum Chiropractic takes pictures and videos for clinical and training purposes, these may be used in office promotion, fliers, social networks, such as Facebook, Instagram or Youtube and/or the website [www.platinumchirout.com](http://www.platinumchirout.com)

- ☐ I give my permission to take photos and use them for the aforementioned purposes
- ☐ I do NOT give my permission for photos of any kind

Signature:

---

Date:

---

Guardian or spouse authorizing care signature:

---

Date:

---

## What Platinum Chiropractic is all about...

**Our Mission:** To provide a foundation on which families can build a healthy and abundant lifestyle for generations.

**Our Vision:** Educating, Empowering, and Inspiring healthy members of our community by providing Platinum quality chiropractic care to families.

### **Our Core Values:**

**Excellence:** We want nothing less than the best quality chiropractic experience. From your first step in our door, to the educational elements in the consultation room, to the hands-on care in the adjusting room, each member of our team is committed to excellence.

**Authenticity:** Each member of our team behaves in a manner that allows him or her to stay true to one's own personality, spirit, and character. We are committed to honoring that space for our patients. In all we say and do, we pledge to have clarity and transparency in our communication.

**Integrity:** We adhere to a code of having high professional values as well as high moral values when caring for each person that walks through Platinum's doors.

**Love:** Our service to our community is rooted in an unselfish and compassionate concern for the good of everyone we care for. Our love of the job, passion for life, and care for each other drives us to create memorable and helpful wellness experiences.

**Fun:** At our core, we all have what we call "Big Silly Goose Energy." We allow fun, humor, joy, and laughter at every point of our office. Whether we are caring for a baby, a child, or a family, our goal is to create a space that feels safe, fun, and enjoyable.