PATIENT CONSENT

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

RELEASE OF INFORMATION:
By signing the form, you are granting consent to **Anderson Wellness Center and Dr. Steely** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our HIPPA Notice of Privacy Practices provides more detail information about how we may use and disclose the protected health information. You have a legal right to review our HIPPA Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our HIPPA Notice of Privacy Practice is subject to change. If we change our HIPPA Notice, you may obtain a copy of the revised notice by telephoning our office at **864-226-7676**. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration of its intermediary carriers, any information needed for this or related Medicare or Medicaid Claims.

VERIFICATION OF NON-PREGNANCY (FEMAIL PATIENTS ONLY):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period_____.

X _____
Print Patient's Name

X_____
Patient's Signature

X_____
If other than patient, print name & relationship

X_____
Witness

Case Notes

Date: _____ Dr. Kristen Steely

Anderson Wellness Center

1704 East Greenville St.
Suite C
Anderson, S.C. 29621
Tel. (864) 226-7676

Kristen M. Geles, D.C.
Chiropractic Physician

Most of the patients that visit our office are on an affordable cash wellness plan. If you plan on using your health insurance, please provide the following information necessary for us to bill your insurance carrier.

Who is responsible for this account? _____
Relationship to patient? _____
Insurance Company _____
Policy ID # _____
Group # _____
Subscriber's Name _____
Birthday of Subscriber _____
Social security # of subscriber _____
Social security # of patient _____
Subscriber's employer _____

Assignment and release:

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Geles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above – named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient's signature _____

Guarantor's signature _____