Health Information Notification/Communication Form:

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. Please read the below and if you have any questions, please feel free to ask one of our staff members.

In order to assist you in receiving or sharing your protected health information from Restoration Health Chiropractic (RHC), please complete this form. I authorize the person(s) listed below to have access to any & all of my health information relative to my chiropractic care at "RHC". "RHC" is permitted to share any chiropractic & medical information from my treatment files including test results & information disclosed during my visits. In the event that we would need to communicate your healthcare information, to whom may we do so?

NAME	RELATIONSHIP	PHONE NUMBER
___________________________	_______________________	______________________
___________________________	______________________	_______________________
___________________________	_______________________	_______________________

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

May we use your name on our Thank-You Referral board in acknowledgement of your trust in referring relatives & friends? Yes [ ] No [ ]

May we use your name & pictures on our social media accounts & our website pages in acknowledgement of your trust in our services and in sharing highlights of our practice events? Yes [ ] No [ ]

May we send email appointment reminders, birthday & holiday greetings and notices of special offers, events, articles of health interests and our monthly newsletter to the email you have provided. You will have the option to opt out at any time? Yes [ ] No [ ]

I, ____, have read and fully understand the above statements.

Acknowledgement

I have been given the option to review the notice of privacy practices (HIPAA) for "RHC" and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy. I understand and direct that this authorization remain in effect until revoked by me in writing.

Print Name: _________________________ Signature: __________________________ Date: ________________

Health Insurance Portability and Accountability Act (HIPAA) and Patient Consent Form

I understand and have been provided with the opportunity to review a ***Notice of Privacy Practices*** that provides a more complete description of information of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be disclosed to carry out treatment, payment or health care operations.

Florida Insurance Commissioner

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the FL Insurance Commissioner (FLIC). This disclosure will be made if we need the FLIC's assistance to receive reimbursement for your services or, we need the FLIC's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form, you are giving us authorization to send the FLIC this information. You are also giving the FLIC authorization to re-disclose your information to the party responsible for the payment of your services, the FLIC counsel, and state or federal agencies that may be asked to intercede on your behalf. I hereby give my consent for Restoration Health Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Appointment Reminders and Health Care Information Authorization

Dr. Martingano and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your voicemail.

By signing this form, you are giving us authorization to contact you with these reminders and information.

_______________________________ _______________________

Patient Signature **Date**

If not signed by the patient, please indicate relationship:

- ❏ Parent/Guardian
- ❏ Guardian or conservator of an incompetent patient
- ❏ Beneficiary or personal representative of deceased patient

Name of Patient: ____