HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

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

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations Privacy officer to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my confidential information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I have the right to revoke this consent in writing signed by me. However, such a revocation will not be retroactive

Patient Name(printed): _____

Signature: _____ Date: _____

Relationship to Patient (if minor) _____

Consent for Evaluation and/or Treatment

By signing below, I am giving my consent to the practice of Arizona Spine Consultants for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline.

Patient Name(printed): _____

Signature: _____ Date: _____

Relationship to Patient (if minor) _____

Contact Information

May we leave a message concerning your test results? What is the Best #? (_____)_____-_____

On your answering machine/voicemail? Yes or No

Office/Work Voicemail? Yes or No

With another Person? Yes or No

Please list the person(s) with whom we can discuss your protected health information?

_____
_____
_____
_____

Cancellation Policy

To serve our patients better, we have instituted a cancellation policy. We require 24-hour notice for all cancellations. As a courtesy, reminder calls are made 2 days before your appointment to allow for you to contact us in the event you need to cancel or reschedule your appointment. We ask that you provide us with the same courtesy. If an appointment is missed, cancelled or rescheduled without 24-hour notice there will be a $25.00 charge billed to the patient. (courtesy removal for Emergencies or sickness)

If a surgical or pre-op appointment is missed, cancelled or rescheduled without 24-hour notice there will be a $50 charge billed to the patient. By signed below I am acknowledging that I have been notified of the cancellation policy.

Patient Signature: _____Date: _____

Parent/Guardian Sig. (if applicable): _____ Date: _____

Relationship to Patient (if applicable): _____