FINANCIAL RESPONSIBILITY AGREEMENT
AND RECORD REQUEST

Patient name: ________________________________ SSN: ____________________ Birth date: ___________

Billing Address: ____

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Home Phone: __________________ Work Phone: __________________ Cell Phone: __________________

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of, any insurance carrier, attorney, health care provider, hospital, or immediate family member.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

Privacy: The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the ***Health Insurance Portability and Accountability Act*** of 1996 ("HIPAA") A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines.

I have read and understand the foregoing. I have also received a copy of the HIPAA privacy statement and Fogarty Chiropractic Life Clinic's Fee Sheet.

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Date   Patient / Legal Guardian Signature