Dr. Allison Zak D.C., LLC

220 1st St. S.E.
Little Falls, MN 56345
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Pierz, MN 56364
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Notice of Privacy Practices

Patient Name: ____ Date of Birth: ________

RELEASE OF INFORMATION TO AND FROM HEALTH CARE PROVIDER: This clinic is authorized to release or request all or part of the patient's medical record to or from health care providers involved in follow-up or subsequent care. This clinic is further authorized to release such information as may be necessary or required for statistical reporting, and health care review purposes, or as required by applicable law. I understand a photocopy of this form is authorization for release or request.

RELEASE OF INFORMATION FOR INSURANCE CLAIMS: This clinic is authorized to release all or part of the patient's medical record to an person or corporation, which is or may be liable for part of clinic's charges including but not limited to, hospital or medical service companies, insures, compensation carriers, or government agencies. I understand a photocopy of this form is authorization for release.

ASSIGNMENT OF INSURANCE BENEFITS: I certify that the information given by me in applying for payment under Title XVII (Medicare) and or Title XIX (Medicaid) of the Social Security Act and or any other governmental health care program and or from any other third-party insurer or payer is correct. Furthermore, I authorize anyone having medical or other benefits to release and to secure from the Social Security Administration, the Medicaid Assistance Program or to other agencies or entities administering the Medicare, Medicaid or other insurer claims. I request that payment of authorized benefits be made on my behalf to the clinic, physician and to any other health care provider qualifying for reimbursement for such medical and treatment, including consultation, provided to consultation, provided to me. I Understand I am financially responsible for charges not covered by this assignment.

FINANCIAL RESPONSIBILITY: In consideration of the services to be rendered to the patient during this period of care. I guarantee the payment of any amount due for such services rendered by clinic providers, and I assume financial responsibility for medical expenses of the patient.

RECEIPT OF NOTICES: I acknowledge a receipt of the clinic's Notice of Privacy Practices. I also acknowledge that when registering for this period of care, I was offered information regarding the clinic's Grievance Policy, Patient Rights and Responsibilities.

CERTIFICATION: I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and agree to accept the terms of this document.

NO SHOW POLICY: When a patient doesn't make it to a scheduled appointment, this is time another patient could have taken to receive the care they need. Please help us deliver the care our patients need as efficiently as possible by calling prior to your appointment if you are not able to keep your appointment. Please be advised if you have missed two appointments, we have the right to dismiss you from our care. After your first missed appointment a letter will be mailed to you and placed in your chart. This letter will state you have missed an appointment and remind you of our policy's. After a second missed appointment a letter will be mailed to you again explaining the policy and advise you that you are not allowed to schedule any additional appointments in our office. While this may seem extreme to some, please realize that this will help ensure that you can be seen when needed. Also please note that arriving more than 15 minutes late for an appointment will be considered a “no show”. We understand extenuating circumstances arise and this policy will be considered on the circumstances of the patient. If you have any questions please talk to our staff.

Consent for Use and/or Disclosure of Protected Health Information:
I hereby give consent to Dr. Allison Zak D.C. LLC to use and disclose my protected health information for the purposes of treatment, payment and health care operations. Our notice or Privacy Practices provides for detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You have the right to request a current copy of our Notice of Privacy Practices. 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 to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you (or on your behalf), and delivered to the address at the top of this form. You may deliver your revocation by any means you choose (i.e., personally or by mail), but it will be effective only when received. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Signature: ____ Date: _______________

I also give authority to release my Protected Health Information to:

____ ____

Name Date of Birth Relationship to Patient

Revised 05/23/2018