



**Your Wellness Connection, P.A.**  
 7410 Switzer  
 Shawnee Mission, KS 66203  
 Phone (913) 962-7408 Fax (913) 962-7416

**Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my medical information by Your Wellness Connection (YWC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of YWC.

I understand that diagnosis or treatment of me by YWC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. YWC is not required to agree to the restrictions that I may request. However, if YWC agrees to a restriction that I request, the restriction is binding on YWC.

I have the right to revoke this consent, in writing, at any time, except to the extent YWC has taken action in reliance on this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review YWC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of YWC.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of YWC.

This Notice of Privacy Practices also describes my rights and the duties of YWC with respect to my medical information.

YWC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ Signature of Patient or Personal Representative	_____ Date
_____ Name of Patient or Personal Representative	_____ Description of Personal Representative's Authority

**FOR OFFICE USE ONLY**

I attempted to obtain the client's signature in acknowledgement of this Consent for Purposes of Treatment, Payment and Health Care Operations, but was unable to do so as documented below.

_____ Date	_____ Initials	_____ Reason
(Please see other side)		





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### **NOTICE: PATIENT PRIVACY**

We are committed to preserving the privacy of your medical information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

#### **HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

We may require your written consent before we use or disclose to others your medical information for purposes of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations of Your Wellness Connection (YWC).

**\*Treatment** includes activities performed by a practitioner, chiropractic assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers.

**\*Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

**\*Health Care Operations** includes the necessary administrative and business functions of our office.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This Notice is posted in our lobby. We may revise our Notice from time to time. The effective date at the lower left-hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our Privacy Officer at (913) 962-7408.

(Please see other side)

