Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

Request to Restrict Disclosure to Health Plan

I, ____ on ______________________

Name of Patient (Print) Date

understand and agree to the following (please initial next to each statement):

This clinic/provider may or may not be a participant in my health plan, ____.

Name of Health plan

_________ I understand that there may be mandatory submission of my bills to the health plan associated with that participation.

_________ I DO NOT PERMIT this office to submit a claim to my health plan, for the services provided to me in this office. This includes benefits for some or all the services that are provided by this office/provider.

_________ Until such time that I advise otherwise in writing, I elect to pay at the time of service, for all services rendered in this office and restrict this office/provider from sharing my Protected Health Information with my health plan, such information to include but not be limited to my diagnosis, history, and other medical record documentation necessary for third-party payment.

_________ By electing to self-pay for services, any payments I make to this office will NOT be credited toward satisfying any deductible that I may be subject to under my health plan.

_________ I understand that I am responsible for the full fee for services rendered at this office, and by choosing to self-pay, am not entitled to third-party discounts otherwise available to me through my health plan. I understand that I may qualify for other types of discounts offered through this office, such as financial hardship, Discount Medical Plan Organization (DMPO) membership, professional courtesy, and the like.

_________ By electing to self-pay, I also understand that it is inappropriate for me to attempt to send in my receipts to my health plan for reimbursement of what I have paid and agree not to submit my services to the payer, on my own.

_________ I understand that I must submit a written request to terminate this restriction in order to reinitiate claim submission.

I have read and understand this Request for Restriction of Use and Disclosure of PHI, and freely choose to self-pay rather than to use my health benefits. I have had the opportunity to ask questions I may have about this form, about submission of my claims, and about the way my Protected Health Information (PHI) will be safeguarded. I choose to exercise my rights under the Health Insurance Portability and Accountability Act (HIPAA) to restrict this information from my health plan and pay for my services out of pocket.

Patient Signature: ____

Address: ____

City ____State________ Zip ____________

Office use only

______________________________ ____ __________________

Practice Representative Name (print) Practice Representative Signature Date

○ Entered Alert in Patient Chart ○ Notified Parties involved with claim submission.

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