Policy on Releasing X-Rays

This office takes x-rays (radiographs) when medically necessary. Our Policy on x-rays and copies of notes follow state law.

Health and Welfare

191.227 Medical records to be released to patient, when, exception-free permitted, amount-liability of provider limited. – 1. All physicians, chiropractors, hospitals, dentists, and other duly licensed practitioners in this state, herein called "providers", shall, upon written request of a patient, or guardian or legally authorized representative of a patient, furnish a copy of his record of that patient's health history and treatment rendered to the person submitting a written request, except that such right shall be limited to access consistent with the patient's condition and sound therapeutic treatment as determined by the provider. Beginning August 28, 1994, such record shall be furnished within a reasonable time of the receipt of the request therefore and upon payment of a handling fee of fifteen dollars plus a fee of thirty-five cents per page for copies of documents made on a standard photocopy machine.

2. Notwithstanding provisions of this section to the contrary, providers may charge for the reasonable cost of all duplications of medical record material or information which cannot routinely be copied or duplicated on a standard commercial photocopy machine.

3. The transfer of the patient's record done in good faith shall not render the provider liable to the patient or any other person for any consequences which resulted or may result from disclosure of the patient's record as required by this section.

(L. 1988 H.B. 925 § 1,A.L. 1994 H.B. 1427)

This office does **NOT** release original x-rays. **WE WILL HAVE COPIES OF SUCH IN TWO (2) BUSINESS DAYS AFTER THE REQUEST. THE COST MUST BE PRE-PAID AND IS $15 PER SHEET.**

THE COST FOR MEDICAL RECORDS (NOTES) IS $15 PLUS 35¢ PER PAGE.

I do understand this and agree to this.____________________
Patient's Initials and Date

VERIFICATION OF INSURANCE COVERAGE and RELEASE OF PAYMENT

Lockhart Chiropractic Inc.
PO Box 792
Marshall, MO 65340-0792

I agree that the copy of the insurance card is actual and correct. ________________
PATIENT'S INITIALS AND DATE

I authorize the doctor and staff named above to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.__________________
Patient's Initials and Date

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor/clinic named above as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.__________________
Patient's Initials and Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

This office does utilizes:

- An open sign in sheet
- Greet people by their first and/or last name
- Display patient stories on wall space and in notebooks
- Utilizes an open adjusting and therapy area.

Medical and/or private information will **not** be disclosed without permission.

I agree to these specific practices in this office. I acknowledge I have the right to receive a full copy of the Notice of Privacy Practices upon written request and/or the right to review the Notice of Privacy Practices in person at any time I am physically in the office.

____
Patient's Initials and Date

____ Patient's Signature and Date

____ Witnesses Signature and Date