Entrance Form Privacy Clause

We value patient privacy and act to ensure that it is protected. Our Privacy Officer is responsible for any of your privacy concerns. We are committed to collecting, disclosing, retaining, and disposing of your personal health information responsibly. We follow provincial and federal privacy legislation in regards to handling of your personal health information.

Collection of Personal Health Information

Windermere Chiropractic, Physiotherapy, and Acupuncture clinic will follow provincial and federal privacy legislation in regards to collecting, retaining, and disposing of personal health information. All our clinic staff has signed confidentiality agreements. You may call our clinic to speak with our Privacy Officer if you have any concerns. We use Jane Software Inc. (a third party service provider) to store and process your data. Your data is stored on very secure servers in a certified SOC2 Type2 audited facility. The following are reasons why we would use or disclose your personal health information:

-To help with providing safe patient care (assessing, treating, plan of management of your health concerns, and providing you with treatment options)

-To use when communicate with other treating healthcare providers (including but not limited to massage therapists, acupuncturists, physiotherapists, and medical doctors)

-To comply with the law (legal and regulatory rules) including delivery of patient's chart notes to governing bodies when required according to the provisions of the Regulated Health Professions Act

-To allow us to contact you to establish communication (via phone, email, and voicemail) regarding treatment, follow-up on treatment, provide health care information, billing, to book and confirm appointments.

-To invoice for goods and services

- To submit and complete your claim to your extended health insurance provider

-To collect unpaid accounts and to process credit card payments

We will seek your approval in advance if a new reason requires us to use and/or disclose your personal information. Your information may be accessed for the defense of a legal issue and/or by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA). Your confidential medical history will not be given to your insurer without your consent. When unusual requests for your personal health information are received, we will contact you for permission to release it.

Patient Consent

I have reviewed the above information regarding the use of my personal information, and the steps taken to protect my information. I am giving my informed consent to use and/or disclose my personal information for the reasons listed above. I authorize Grange Lewis Estates Chiropractic, Massage, and Acupuncture Clinic to collect, use and disclose my personal health information for the reasons identified above. I understand the risks and benefits of consenting or refusing to consent. I understand I may revoke this consent in writing at any time.

Date of Consent: _____(DD-MM-YYYY)

_____ _____

Name of Patient/Client or Authorized Representative **Signature**

_____ _____

Name of Witness **Signature**

Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

***Provider: Grange Lewis Estates Chiropractic & Massage Clinic (Tel: 780-483-5377)**
Address: 2576 Guardian Rd NW Edmonton, AB, T5T 1K8

***Provider: Windermere Chiropractor & Physiotherapy Clinic (Tel: 780-628-2881)**
Address: 6279 Andrews Loop SW Edmonton, AB, T6W 3G9

***Patient:** _____ **Phone Number:** _____-_____-_____
Address: _____**City/Province:** _____**Postal Code:** _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes. I authorize the insurer and / or plan administrator and their service provider(s) to:

*use my personal information for the above purposes.

*exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

* exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.

*exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

_____ _____

Date: **Signature**

Print Name: