



Comprehensive Treatment

- *Low back & neck pain*
- *Persistent Headaches*
- *Radiating Pain*
- *Sports Injuries*
- *Stress / Tension*
- *Pediatric Chiropractic*

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Quality Chiropractic Care

- *Convenient Service Guaranteed*
- *Computerized Posture Analysis*
- *Massage Therapy*
- *Nutritional Assessment*
- *New Patients Welcome*
- *HMO/PPO Provider*

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice’s Privacy Policy has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its healthcare operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice further explained my right to obtain a copy of the Privacy Notice prior to my signing the Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
  - a) A post card mailed to me at the address provided by me: and
  - b) Telephoning my home or cell phone and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/ or disclose my PHI (which includes my information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have a right to revoke this Consent, in writing, for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has a right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature of Legal Representative \***

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Witness**

**\*Attorney-In-Fact, Guardian, Parent if a minor**