ADVANCED
CHIROPRACTIC CLINIC

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PATIENT CONSENT

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice 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 would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this 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. The Practice's "Notice of Privacy Practices" is also posted in the office reception area. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.
5. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
6. The Practice may use and/or disclose my PHI (which includes 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.
7. 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 health care 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.
8. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time 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.
9. I understand that if I do not sign this consent or revoke consent at any time, the Practice has the right to refuse to treat me.
10. I understand and consent to the following other types of correspondence from this office:
    a. a birthday card may be mailed to me at the address I provided; and,
    b. I may receive periodic mailings of general health information in the form of a newsletter.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)		*Signature of Individual*
Signature of Legal Representative	*Date Signed*	*Relationship*
Witness		

Reviewed and Updated: 10-16-09
By SJ Troyanovich, DC