Patient Consent

Use and Disclosure of Protected Health Information

I hereby give my consent for Arlington Chiropractic & Acupuncture to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right and had the opportunity to review the Notice of Privacy Practices prior to signing this consent. I understand Arlington Chiropractic & Acupuncture reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Arlington Chiropractic & Acupuncture at PO Box 302, Arlington, SD 57212.

With this consent, Arlington Chiropractic & Acupuncture may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Arlington Chiropractic & Acupuncture may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Arlington Chiropractic & Acupuncture may e-mail or text message to me any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, practice newsletter, and educational information. I have the right to request that Arlington Chiropractic & Acupuncture restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Arlington Chiropractic & Acupuncture to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Arlington Chiropractic & Acupuncture may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

_____ _____

Print Patient’s Name Date

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Print Name of Patient or Legal Guardian, if applicable