

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that the **Chelsea Chiropractic Center, PLC**, “Notice of Privacy Practices” has been made available to me.

I understand I have a right to review Chelsea Chiropractic Center’s “Notice of Privacy Practices” prior to signing the document. Chelsea Chiropractic Center’s “Notice of Privacy Practices” has been made available to me. The “Notice of Privacy Practices” describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chelsea Chiropractic Center, PLC. The “Notice of Privacy Practices” for Chelsea Chiropractic Center, PLC. is also provided upon request at the main administration desk of the practice. This “Notice of Privacy Practices” also describes my rights and Chelsea Chiropractic Center’s duties with respect to my protected health information. This also allow us to call your name aloud in the reception room,, put your name on the referral board, send you postcards or newsletters and signing in on the sign in sheet every visit.

Chelsea Chiropractic Center, PLC. reserves the right to change the privacy practices that are described in the “Notice of Privacy Practices”. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Print name of Patient or Personal Representative

Description of Personal Representative’s Authority

Name of Person(s) Authorized to Gain Access to Account Information