



The Chiropractic Associates, LLC

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Consent for Purposes of Treatment, Payment & Healthcare Operations (9/07)

(In this document, “I” and “my” refer to the patient.)

I consent to the use or disclosure of my protected health information by The Chiropractic Associates for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operation of The Chiropractic Associates. I understand that analysis, diagnosis or treatment of me by The Chiropractic Associates may be condition upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractic Associates is not required to agree to the restrictions that I may request. However, if The Chiropractic Associates agree to a restriction that I request, the restriction is binding on The Chiropractic Associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Chiropractic Associates has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is available to all patients and 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 The Chiropractic Associates. The Notice of Privacy Practices for The Chiropractic Associates is also posted in the waiting room at 517 Wythe Street, Alexandria, Virginia. This Notice of Privacy Practices also describes my right and duties of the Chiropractor with respect to my protected health information.

The Chiropractic Associates 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 practice by calling the office of The Chiropractic Associates and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Description of Personal Representative’s Authority

Date of Signature