Kutschman Chiropractic & Acupuncture Center
Natural Healthcare for the Whole Family

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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 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) NECESSARV 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 HEALTH CARE OPERATIONS. THE PRACTICE EXPLAINED TO ME THAT THE PRIVACY NOTICE WILL BE AVAILABLE TO ME IN THE FUTURE AT MY REQUEST. THE PRACTICE HAS 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 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 THAT WILL BE USED BY THE PRACTICE: A) A POSTCARD MAILED TO ME AT THE ADDRESS PROVIDED BY ME; OR B) TELEPHONING MY HOME 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 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 NECESSARY FOR THE PRACTICE TO CONDUCT ITS SPECIFIC HEALTH CARE OPERATIONS.

5. I UNDERSTAND 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 RESTRICTION, THE RESTRICTION IS BINDING ON THE PRACTICE.

6. 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.

7. I UNDERSTAND THAT IF I REVOKE THIS CONSENT AT ANY TIME, THE PRACTICE HAS THE 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.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

NAME OF INDIVIDUAL:____

SIGNATURE OF REPRESENTATIVE:_____________________________________

DATE:____________________ WITNESS:______________________________