Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge the **Alternative Healing Chiropractic Center, PLLC.** "Notice of Privacy Practices" has been provided to me.

I understand that I have the right to review **Alternative Healing Chiropractic Center's** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosers of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of **Alternative Healing Chiropractic Center, PLLC.** The Notice of Privacy Practices for **Alternative Healing Chiropractic Center** is also provided on request at the main administration desk of this practice. The Notice of Privacy Practices also describes my rights and **Alternative Healing Chiropractic Center's** duties with respect to my protected health information.

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

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority