

## **CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

I acknowledge that Heumann Chiropractic Office's "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Heumann Chiropractic Office's Notice of Privacy Practices prior to signing this document. 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 Heumann Chiropractic.

The Notice of Privacy Practices for Heumann Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Heumann Chiropractic's duties with respect to my protected health information.

Heumann Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by mail or ask for one the time of my next appointment with Heumann Chiropractic.

I have the right to revoke this consent, in writing, except to the extent that Heumann Chiropractic has taken action in reliance on this consent.

### **PATIENT ACKNOWLEDGEMENT**

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority