Notice of Privacy Policies & Consent for Purposes of Treatment Payment

Family Chiropractic & Wellness Center

Patient Name: ____

I consent to the use or disclosure of my protected health information by the staff of Dr. Craig A. Beuttler Chiropractic Corporation and/or Family Chiropractic &Wellness Center (hereinafter "the office") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the medical practice. I understand that diagnosis or treatment of me by "the office' may be conditioned upon my consent as evidenced by my signature on this document.

I have the right to revoke this consent, in writing, at any time, except to the extent that "the office" has taken action in reliance on this consent. Otherwise, this consent is good for a period not to exceed 6 years from the signed date.

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 clearing house. 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 I have the right to review "the office" Notice of Privacy Practices prior to signing this document, upon my request, and it is available upon my request. The notice of Privacy Practices describes in more detail 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 office." The Notice of Privacy Practices for "the office" is also available in the medical office waiting area. The Notice of Privacy Practices also describes my rights and duties with respect to my protected health information.

"The office" 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 by mail or asking for one at the time of my next appointment. Any questions regarding this document or the Notice of Privacy Practices should be directed to the office manager.

I request the following restrictions on the use and/or disclosure of my protected health information:

Please check one: _____ Restricted to use only by "the office" as stated above

_____ Restricted use within the office for purposes such as testimonials,
Success stories, public case studies, etc.

____ _________________________

Signature of Patient or Personal Representative **Date**

____ _________________________

Signature of Office Representative **Date**