Heartland Family Chiropractic, PLLC

PATIENT CONSENT

FOR USE AND/ OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows.

1. **Heartland Family Chiropractic LLC (HFC)** Privacy Notice has been made available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI) necessary for **HFC** to provide treatment and to carry out other healthcare operations. **HFC** explained to me that the privacy Notice will be available to me in the future at my request. **HFC** has further explained my Privacy Notice carefully prior to my signing this Consent.
2. **HFC** reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. Revisions of Privacy Notice will be made available to me.
3. I understand that, and consent to, the following appointment reminders that will be used by **HFC**: a.) telephone calls with detailed messages left on answering machine or with individuals that answer the phone, and b.) appointment reminder postcards.
4. I understand that, and consent to, the following policy observed by **HFC**: sign in sheets are located in a position where staff can readily see who is seeking care in the office: this information may be seen by, and is accessible to, other persons who are in the office.
5. I understand that, and consent to, the following policy observed by **HFC:** spinal manipulation and cervical tractioning are performed in an open adjustment setting therefore, adjustments may incidentally be seen, and conversations may be overheard in this situation by other persons who are in the office.
6. **HFC** may use and/or disclose my PHI in order for **HFC** to treat me and collect payment for that treatment, and as necessary for **HFC** to conduct its specific health care operations.
7. I understand that I have a right to request that **HFC** restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, **HFC** is not required to agree to any restrictions that I have requested. If **HFC** agrees to a requested restriction, then the restriction is binding on **HFC**.
8. 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 **HFC** has already taken action in reliance on the consent.
9. I understand that if I revoke this consent at any time, **HFC** has the right to refuse to treat me.
10. 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 **HFC** will not treat me.

___ I understand, **and consent**.

___ I understand, **but do not consent.**

I have read and understand the forgoing notice, and all my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Patient/ Guardian Signature Date

_____ _____

Witness Date