

HIPAA

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Chiropractic & Massage of North Port's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Chiropractic & Massage of North Port's Notice of Privacy Practices prior to signing this document. Chiropractic & Massage of North Port's Notice of Privacy has been provided for me. 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 operations of Chiropractic & Massage of North Port. I understand that Chiropractic & Massage of North Port has an open treatment area. I understand that patient data is confidential and I will not obtain it or disseminate information if it is not my right to do so. Cameras in the treatment area and pictures of other patients are strictly prohibited unless authorized to do so. The Notice of Privacy Practices for Chiropractic & Massage of North Port is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Chiropractic & Massage of North Port's duties with respect to my protected health information.

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

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

CHIROPRACTIC & MASSAGE
—OF—
NORTH PORT

14942 Tamiami Trl Ste L North Port, FL 34287

Chiropractorinnorthport.com

Ph: 941-564-8083

Fax: 941-564-6248

If Not the Patient: Description of Personal Representative's Authority