Chiropractic Care Center, NW, P.S., Inc.

Paul M. Scott, D.C.

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Consent for Purposes of Treatment, Payment and Health Care Options

I consent to the use or disclosure of my protected health information by Chiropractic Care Center NW, P.S., Inc. For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractic Care Center NW, P.S., Inc.

I understand that diagnosis or treatment of me by Chiropractic Care Center NW, P.S., Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry our treatment, payment or health care operations of the practice. Chiropractic Care Center NW, P.S., Inc. is not required to agree to the restrictions that I may request. However, if Chiropractic Care Center NW, P.S., Inc. agrees to a restriction that I request, the restriction is binding on Chiropractic Care Center NW, P.S., Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractic Care Center NW, P.S., Inc. has taken action in reliance on this consent.

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 clearinghouse. 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 a right to review Chiropractic Care Center NW, P.S., Inc.'s Notice of Privacy Practices prior to signing this document.

The Chiropractic Care Center NW, P.S., Inc.'s Notice of Privacy Practices has been posted at the front counter. Copies are also available upon request.

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 the Chiropractic Care Center NW, P.S., Inc.

Chiropractic Care Center NW, P.S., Inc. 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 in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient

_____

Date

_____

Description of Personal Representative's Authority