Consent For Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that C&R Family Chiropractic Center's "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review C&R Family Chiropractic Center'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 C&R Family Chiropractic Center.

The Notice of Privacy Practices for C&R Family Chiropractic Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for on at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that C&R Family Chiropractic Center has taken action in reliance on this consent.

Patient Acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of 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