

**DeBlon Chiropractic Offices
Consent Agreement**

**Consent to the Use and/or Disclosure of Health Information for
Treatment, Payment or Healthcare Operations.**

I _____, understand that as part of my treatment and care, this office creates and maintains health records describing my medical history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and/or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the many healthcare professionals who contribute to my care.
3. A source of information for applying my diagnosis and surgical information to my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of our staff.
6. To call you and remind you of appointments.
7. To discuss you test results and treatment plan.

I understand if I wish to obtain a copy of the Office's Notice of Privacy Practices, that provides a more complete description of information uses and/or disclosures, one will be made available for me. I understand that I have the right to review the Notice prior to signing this consent. I understand that this Office reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised Notice of the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this Office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except that for actions taken by this Office in relying on such information.

I understand and authorize, that at times it will be necessary for this Office to call my home or place of business and leave messages on an answering machine, voice mail or E-mail.

I fully understand and accept decline the terms of this consent.

Patient's Signature

Date