Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Crossroads Chiropractic Center's "Notice of Privacy Practices' has been provided to me.

I understand I have a right to review Crossroads Chiropractic Center's Notice of Privacy Practices prior to signing this document. Crossroads Chiropractic Center'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 Crossroads Chiropractic Center. The Notice of Privacy Practices for Crossroads Chiropractic Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Crossroads Chiropractic Center duties with respect to my protected health information.

Crossroads Chiropractic Center 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.

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Signature of Patient or Personal Representative Date

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Name of Patient or Personal Representative

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Description of Personal Representatives Authority