

ORR CHIROPRACTIC CENTER

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____ (*print patient name*), understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Health Information Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. 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 the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

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

Patient/Guardian Signature _____ Date _____

- Dental Visits: Every 6 months Yearly Toothache/Emergency Only None
- List any medications your are taking and why: (prescription and non-prescription) _____
• _____

- Please list ALL recreation accidents, sports injuries, auto accidents, etc. and the year in which they occurred:

- As a result of my chiropractic care, I would like to: (please check all that apply)
____ feel better quickly ____ have a healthier body by keeping my nervous system healthy
____ have a healthier spine ____ live a healthier lifestyle & have a better quality of life