



776 W. Bartlett Road
Bartlett, IL 60103
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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Balance Family Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations at Balance Family Chiropractic. I understand that Dr. Ackerman may refuse to diagnose or treat me if I do not consent to the use or disclosure of my protected health information for the above stated purposes. **My signature on this document is evidence of this consent.**

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Balance Family Chiropractic is not required to agree to the restrictions that I may request. However, if Balance Family Chiropractic agrees to a restriction that I request, the restriction is binding on Balance Family Chiropractic and Dr. Ackerman.

I understand that I have a right to review Balance Family Chiropractic’s Notice of Privacy Practices prior to signing this document. Balance Family Chiropractic’s Notice of Privacy practices has been provided to me. The Notice of Privacy Practices for Balance Family Chiropractic is also provided on request at the front desk of this practice. Notice of Privacy Practices also describes my rights and Balance Family Chiropractic’s duties with respect to my protected health information. Balance Family Chiropractic 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 Balance Family Chiropractic’s office and request a revised copy to be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that Balance Family Chiropractic or Dr. Ackerman has taken action in reliance on this consent.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative’s Authority