

**AGEE CHIROPRACTIC CENTER, P.C. CONSENT FOR PURPOSES OF TREATMENT,  
PAYMENT AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, {Name of Individual} consent to Agee Chiropractic Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general health care operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or the treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of healthcare to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practices, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to restriction that I request, the restriction is binding on the Practice. I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my right and the Practice's duties regarding the types of uses and disclosures of my Protective Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has active in reliance on this consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, {Patient's Name} acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Agee Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness