Chiropractic Arts Center of Austin, P.C.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Notice of Privacy Practices that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to/for:

- Conduct, plan and direct my care and follow-up among multiple healthcare providers who may be involved in my care directly and indirectly.
- Obtain payment and/or payment information for services, confirming insurance coverage per your request, and billing or collection activities.
- Health care operations, which include the business aspects of running our practice. Examples of this would include posting of our daily schedules throughout the office, having a sign in sheet, calling to confirm appointments, leaving messages regarding appointments, sending reminder cards in the mail with our practice name on them, using yours or a family members' first and last name while servicing you in our office, discuss with/allow immediate family members/guardians into exam or report of findings process to allow for a better understanding of care options when necessary.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document.

When you sign this consent document, you agree that we can and will use and disclose your health information to care for you, to obtain payment for our services, and to perform health care operations as reviewed above and outlined in our Notice. You can revoke this consent in writing at any time unless we have already cared for you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF CARE, PAYMENT, AND HEALTH CARE OPERATIONS. I ALLOW CHIROPRACTIC ARTS CENTER OF AUSTIN, P.C. OR ITS REPRESENTATIVES TO CONTACT ME AT: HOME CELL WORK EITHER

_____ _____
PRACTICE MEMBER SIGNATURE **DATE**

_____
PRINTED NAME OF PRACTICE MEMBER

_____
RELATIONSHIP TO PRACTICE MEMBER