Simmons Chiropractic Center

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____, consent to Simmons Chiropractic Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment, relation to the payment of services rendered to me, and for the Practice's general healthcare 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 treatment may be conditioned upon my consent as evidenced by my signature on this document.

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Simmons Chiropractic/Dr. Jonathan W. Simmons for any equipment or services provided to me by that organization.

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 condition; the provision of health care 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 Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a 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 Practice describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent in writing, at any time, except to the extent that Dr. Jonathan W. Simmons or the Practice has acted in reliance on this consent.

Signature below is an acknowledgement that you have read the HIPPA Notice of our Privacy Practices:

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient

_____

Printed Name of Patient's Representative and relationship to Patient