Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that the Chiropractic Offices of Villa Linde's **"**Notice of Privacy Practices" has been provided to me.

I understand I have a right to review the Chiropractic Offices of Villa Linde's "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations, and describes my rights and the duties of the Chiropractic Offices of Villa Linde, with respect to my protected health information. This policy is also provided on request at the main administration desk of the practice.

The Chiropractic Offices of Villa Linde 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 the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient

_____
Description of Personal Representative's Authority

May We E-mail You Our Monthly "In Good Hands" Newsletter?

It's easy to read, comes out only once a month, and is full of valuable health tips for staying healthy, living longer, and feeling great!

YES! Please e-mail me your newsletter each month.

My name is: _____

My e-mail address is: _____

Signature: _____

Today's Date: _____