**Consent for the Purposes of Treatment, Payment and Other Health Care Options**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give consent to Causeway Chiropractic and Dr. Christopher J. Bott to use and disclose my Individual Health Information or Protected Health Information for these specific purposes:

1. Providing treatment to me.
2. Relating to the payment of the services this office has rendered me.
3. The general administrative operations this practice provides me.

I understand that I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment and healthcare operation of Causeway Chiropractic but Causeway Chiropractic, is not required to agree to these restrictions. However, if Causeway Chiropractic agrees to such a request, the restriction is binding upon the practice.

**Written and Verbal Communications**

Please read the following and **answer** appropriately.

Can this office send newsletters or other written information to your home? **YES/ NO**

Can this office leave a message at your home? **YES/ NO**

Can this office leave a message at your office? **YES/ NO**

Please read the following and **initial** in the space provided.

**\_\_\_\_\_\_** I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this chiropractic office before I sign this consent form regarding the use and disclosure of my Protected Health Information.

**\_\_\_\_\_\_** I have the right to revoke this consent, in writing, at any time, exempting the chiropractor and practice to the extent that they have already relied upon this consent.

**\_\_\_\_\_\_** I have read, reviewed, understand, and agree to the statement of the Privacy Policy for healthcare services in this office. Causeway Chiropractic, has attempted to provide each patient with a statement of Privacy Policies.

I hereby authorize Causeway Chiropractic and Dr. Christopher J. Bott to disclose my protected health information to the following individual.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative (relationship to patient) Date

Print Name