

# Karges Family Chiropractic

## Patient Consent

I hereby state that by signing this consent, I acknowledge and agree to the following:

1. The Privacy Notice of the office of Karges Family Chiropractic requires signed authorization, from the patient or legal guardian of a minor patient, for the use or disclosure of protected health information.
2. I understand, and consent to, appointment reminders that may be used by Karges Family Chiropractic, including mailed reminders, email reminders, answering machine messages, and messages left with individuals that may answer provided phone numbers.
3. Karges Family Chiropractic may use and/or disclose my protected health information in order for Karges Family Chiropractic to treat me and obtain payment for that treatment, and as necessary for Karges Family Chiropractic to conduct its health care operations.
4. I understand that I have the right to request that Karges Family Chiropractic restrict how my protected health information is used and/or disclosed to carry out treatment, payment and/or health care operations.

However, Karges Family Chiropractic is not required to agree to any restrictions that I have requested, but if Karges Family Chiropractic agrees to the requested restrictions then the restrictions are binding.

5. I understand that I have the right to revoke this consent, in writing, at any time, for all future transactions, with the understanding that any such revocation shall not apply to any transactions that have already taken place with Karges Family Chiropractic.
6. I understand that if I revoke this consent at any time, Karges Family Chiropractic has the right to refuse to treat me.
7. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above, Karges Family Chiropractic will not treat me.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_