ADVANTAGE CHIROPRACTIC, PLLC
1003 Oakhurst Dr. Suite 3
Charleston, WV 25314

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ (name of individual), consent to Advantage Chiropractic, PLLC ("Practice") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating 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 of me may be conditioned upon my consent as evidenced by my signature on this document.

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 payments 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 that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment or payment of 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 have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or the Practice has acted in reliance on this consent.

_____ _____
Signature of Patient or Personal Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (patient's name), acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Advantage Chiropractic PLLC which describes the Practice's policies and procedure regarding the use and disclosure of and of my Protected Health Information created, received, or maintained by the Practice.

_____ _____
Signature Date

_____
Print Name

FOR OFFICE USE ONLY IF NOTICE IS NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgment of _____ (patient's name) receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

Patient Unavailable
Patient Physically Unable
Patient Unwilling

In an effort to obtain the patient's acknowledgment, the Practice has attempted to provide the patient with a Notice of Privacy Practices in following manner (check all that apply):

Personally Mail Phone Follow-Up Other:_____

_____ _____
Jennifer Runyan, D.C. Date
Advantage Chiropractic, PLLC