McKinney Family Chiropractic

700 6th Avenue
St. Albans, WV 25177
304-722-2225

Consent for Purposes of Treatment, Payment and Healthcare Operations

I _____ (Name of Individual) consent to McKinney Family Chiropractic's ("the Practice's") 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 operations 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 physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of healthcare 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 a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices 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 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, understand and agree to the Notice of Privacy Practices of McKinney Family Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Signature

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgment of _____ (patient's name)'s 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 patients acknowledgment, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

Personally Mail Phone Follow up

Other: _____

_____ _____ _____

Date Signature Print Name of Physician

McKinney Family Chiropractic
Name of Practice