Smith Chiropractic Health Center

Ashton Village Chiropractic Health Center, Inc.

For use and/ or disclosure of
Protected Health Information
To carry out Treatment, Payment
And Other Healthcare Operations

_____, hereby states that by signing this CONSENT, I acknowledge and agree as follows:

1. The Practices Privacy Notice has been provided to me prior to my signing this consent. The practice Notice includes a complete description of the uses and/or disclosures of my Protected Health Information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out it's healthcare operations. The practice explained to me the Privacy Notice will be available to me in the future at my request. The Practice further explained my right to obtain a copy of the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.
3. Your protected health information, including your clinical records, may be disclosed to another Healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
4. Your health care records as well as your billing records may be disclosed to to another party, sich as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
5. Your Name, address, phone numbers, email address', and your healthcare records may used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
6. I understand that, and consent to, the following appointment reminders that may be used by the practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, and c) telephoning my cell phone number provided by me and leaving a message on the messaging system of the phone, and d) receiving e-mail to the email address that I have provided. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means at alternative locations.
7. This office utilizes an "Open Adjusting" environment for ongoing patient care. "Open Door Adjusting" involves patients being seen in the adjusting area without barriers. Patients are within sight of one another and some ongoing details of care discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment for taking patient histories, providing examinations, or presenting reports of findings. These procedures are provided in a private confidential setting. The use of this format is intended to make your experience with our office more convenient, efficient, and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open adjusting environment, other arrangements will be made for you.
8. We are permitted and may be required to use or disclose your health information in these following circumstances:
    a. If we provide health care services to you in an emergency.
    b. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
    c. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intended for us to treat you.
    d. If we are ordered by the courts or other appropriate agency.

9. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

10. I understand that this consent is valid for seven years. I further 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 the extent that the practice has already taken action in reliance on this consent.
11. I understand that if I revoke this consent, the practice has the right to refuse to treat me.
12. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the privacy notice, then the Practice will not treat me.

If you have a complaint regarding our privacy practices or any aspect of our privacy activities, or you would like further information about our privacy policies and practices, you should direct your inquiry to: *Dr. Kevin C. Smith, 2875 Holme Ave., Philadelphia, PA 19152.*

This notice is effective as of February 18, 2014. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed)	Signature	Date

If you are a minor or are being represented by another party

Personal Representative (Printed)	Personal Representative Signature	Date

Description of the Authority to act on behalf of the patient. (Parent, Guardian, Etc.)