Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that Harbor Family Chiropractic Center (referred to as HFCC) "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review the HFCC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of the health care operations of HFCC. The Notice of Privacy Practices for HFCC is also provided on request at the main administration desk of this practice and on HFCC's website at www.harborfamilychiropractic.com. This Notice of Privacy Practices also describes my rights and HFCC's duties with respect to my protected health information.

HFCC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing HFCC's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____ _____

Signature of patient or personal representative Date

_____

Patient name (printed)

_____

Description of personal representative's authority