

PATIENT CONSENT FORM

Primary Doctor Information

Primary Doctor Name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____
I give permission to consult with my primary care doctor regarding my health and treatment.
Comments _____
Initials _____ Date _____

Consent for Care

It is my choice to receive chiropractic treatment, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Initials _____ Date _____

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to: Evon Chiropractic, P.C.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I understand that I may be treated in an open room adjusting setting and if at any time I need to relay confidential information to the doctor I will let the doctor know so that I may be taken into a private setting to ensure that the upmost confidentiality and privacy are maintained.

This office values referrals. I understand that if I make a referral and ask about that person only a general answer will be given to ensure their privacy.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___