AXIS SPINAL CARE

Patient Consent

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment, and Healthcare Operations

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The practice's Privacy Notice has been provided to me prior to my signing this Patient Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my 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 its health care operations. The practice explained to me that the Privacy Notice would be available to me in the future at my request. The practice has further explained my right to obtain a copy of the available Privacy Notice prior to my 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. I understand that the practice's "Notice of Privacy Practices"(NOPP) that describes my rights and the duties of this office with respect to my PHI is available to me and that I may request a copy from this office at any time via US Mail.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.
5. 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.
6. I understand and consent to the fact that the majority of the treatments performed at the practice take place in an open adjustment area, and that unless personal information needs to be discussed with the doctor of practice or prior arrangements have been made, I too will be treated in the open adjustment area. I further understand that during my appointment others may also be present in the open adjustment area receiving adjustments and/or other treatments at the same time I am.
7. I understand and consent to the following appointment reminders that will 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.
8. I understand and consent to the following other types of correspondence from this office: a) a birthday card may be mailed to me at the address I provided; and b) I may receive periodic mailings of general health information in the form of a newsletter.
9. 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 the consent.
10. I understand that if I do not sign this consent or revoke consent at any time, the practice has the right to refuse to treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual