

**CONSENT FOR PURPOSES OF  
TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_ consent to Ketchum Chiropractic the 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 Ketchum Chiropractic’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Ketchum Chiropractic’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 Ketchum Chiropractic, 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 health care 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 Ketchum Chiropractic, but that Ketchum Chiropractic is not required to agree to these restrictions. However, if Ketchum Chiropractic agrees to a restriction that I request, the restriction is binding on Ketchum Chiropractic.

I have been given the opportunity to review Ketchum Chiropractic 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. This document is posted in plain view on the front desk near the intake window. Please notify our front desk if you wish to have a copy of our Notice of Privacy practices.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or Ketchum Chiropractic has acted in reliance on this consent.

Ketchum Chiropractic reserves the right to change the privacy practices that are described on the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the next appointment.

\_\_\_\_\_  
Signature of Patient/Personal Representative/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority