
Consent for Purposes of Treatment, Payment and Healthcare
Operations

I acknowledge that Complete Chiropractic & Bodywork Therapies “Notice of Privacy Practices” has been provided to me.

Complete Chiropractic & Bodywork Therapies (hereafter referred to as CCBT) Notice of Privacy Practices has been provided to me. I understand I have a right to review CCBT’s 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 health care operations of CCBT. This Notice of Privacy of Practices also describes my rights and CCBT’s duties with respect to my protected health information.

CCBT 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 calling the office and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please Print Name/Date

Signature of Patient, Guardian or Personal Representative

Description of Personal Representative’s Authority