Gilroy Family Chiropractic Center, PC
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ consent to Gilroy Family Chiropractic Center's ("the Practice's") use and disclosure of my protected health information for the purpose of providing treatment to me, purposes related to the payment of services rendered to me, and for the practice'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 the practice's evaluation or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

For purposes of this consent form, protected health information is to include any information, including my demographic information, created or received by the practice which relates to any past, present, or future physical or mental health condition; the provision of healthcare to me; of the past, present or future payment for healthcare services provided to me; and that either identifies me or from where there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my protected health information for the purposes of payment, treatment, or healthcare operations of the practice, but the practice is not requires to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand that I have the right to review the practice's Notice of Privacy Practices prior to signing this document. The notice describes my rights and the practice's duties regarding the types of uses and disclosures of my protected health information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the physician or practice has acted in reliance to this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

PAYMENT AGREEMENT: I understand that there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all my charges incurred. Notwithstanding denial, reduction of benefits, or failure to pay by my insurance company for any reason, I understand and agree that I am responsible for all remaining charges. A $5.00 late fee will be charged to accounts 30 days past-due. I am also responsible to understand my insurance coverage and to obtain appropriate referrals or authorizations if required by my plan.

Signature of Patient or Personal Representative _____
Date _____