Patient Consent / HIPAA Understanding

I understand that, under the Health Insurance Portability & Accountability of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can/will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Green Oaks Chiropractic Clinic has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I understand that by signing below I give my consent to be examined and treated by Dr. Dedra A. Fite and any/all other staff of Green Oaks Chiropractic Clinic and her Wellness Center. All staff members at Green Oaks Chiropractic Clinic are dedicated to treat me with the utmost respect and professionalism. They will strive to provide me with best chiropractic care and associated therapies they are able to provide. If I have any comments, complaints, or concerns associated with this facility, I will discuss these issues with the Office Manager on site immediately.

_____
Patient Name

_____ _____
Signature Date

_____
Relationship to Patient (if under 18)

_____ _____
Witness Date

Green Oaks Chiropractic Clinic, P.C.
5609 SW Green Oaks Blvd., Ste. 103
Arlington, Texas 76017