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## Consent for Purposes of Treatment, Payment and Healthcare Operations

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I acknowledge that **Mills Chiropractic Center's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Mills Chiropractic Center's Notice of Privacy Practices prior to signing this document. Mills Chiropractic Center's Notice of Privacy Practices has been provided to me. 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 Mills Chiropractic Center. The Notice of Privacy Practices for Mills Chiropractic Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Mills Chiropractic Center's duties with respect to my protected health information.

Mills Chiropractic Center 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 requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority