Hockessin Chiropractic CENTRE

The gentle touch to trust for pain relief and better health

Soothing relief for...
- *Low back pain*
- *Neck pain*
- *Headaches*
- *Sports injuries*
- *Muscle soreness*
- *Arm & leg pain*
- *Carpal tunnel syndrome, TMJ & sinus problems*
- *Workers' Comp.*
- *Personal injury*
- *Automobile injuries*

Special care...
- *Pediatric care*
- *Women's programs, including pregnancy & PMS*
- *Wellness care for optimal health*
- *Full range of treatment plans & high-tech equipment*
- *Massage therapy*
- *CranioSacral therapy*
- *Acupuncture*

Convenient care...
- *Morning, evening & Saturday appointments*
- *24-hour emergency care*
- *Same-day appointments*
- *Most major insurance accepted*
- *Visa & MasterCard welcome*

Patient Consent

You have the right to know how your medical information, also known as **Protected Health Information (PHI)** is going to be used and your rights concerning those records. For a more detailed account of our policies and procedures concerning privacy of medical records refer to our Notice of Privacy Rights.

1. You hereby agree to allow this office to use your **PHI** for the purpose of treatment, payment, healthcare operations, coordination of care and other purposes as outlined in this consent.

2. You only have to give your consent once. It will remain in effect until you revoke it.

3. You can revoke this consent by advising this office in writing that the consent is revoked.

4. By signing this "**Patient Consent**" you agree that this office may provide the following services involving your medical records:
   a. We may call you, leave messages on your answering machine(s) and/or send you postcards to remind you of appointments.
   b. We may call you and discuss treatment as well as test results. We will call the most current phone number in our records and discuss these items with anyone at that number who identifies him/herself as our patient.
   c. We may use your name to thank you for referrals via postcard as well as in our newsletter. A copy of the newsletter will be sent to you.
   d. We may send you information about new services or special events that occur at our office.
   e. We may contact you via email with newsletters and/or in response to your correspondence.

I have read and understand how my **Protected Health Information** will be used and I agree to these policies and procedures.

Date	Signature of Patient or Guardian	Printed Name of Patient or Guardian

Patient ID#

-- OVER --

P: Documents\H I P A A\Patient Consent.doc

"Our highest priority is to quickly relieve your pain and then help you achieve optimal health."

Hockessin Chiropractic Centre, P.A.
724 Yorklyn Road ■ Suite 150
Hockessin, Delaware ■ 19707
(302) 239-8550 ■ Fax: (302) 239-6195

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received from Hockessin Chiropractic Centre their "Notice of Privacy Practices" and I have been provided an opportunity to review it.

Date	Signature of Patient or Guardian	Printed Name of Patient or Guardian

This acknowledgement will be kept as a part of the patient's record at our office.

FOR OFFICE USE ONLY

Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of this "Privacy Notice" could not be obtained because:

- ☐ Patient or Guardian refused to sign
- ☐ Patient was shown "Notice of Privacy" posted in office.
- ☐ Patient was provided with a copy of "Notice of Privacy"
- ☐ Communication barrier prohibited obtaining acknowledgement
- ☐ Emergency circumstances
- ☐ Other: _____

_____

_____

Date _____ Signature of Office Representative