Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Bay Area and Interlochen Chiropractic Associates' "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Bay Area and Interlochen Chiropractic Associates'

Notice of Privacy Practices prior to signing this document. Bay Area and Interlochen

Chiropractic Associates' 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 Bay Area and Interlochen Chiropractic Associates. The Notice of Privacy Practices for Bay Area and Interlochen Chiropractic Associates is also provided on request at the main administration desk of this practice.

This Notice of Privacy Practices also describes my rights and Bay Area and Interlochen Chiropractic Associates' duties with respect to my protected health information.

Bay Area and Interlochen Chiropractic Associates 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 Bay Area and Interlochen Chiropractic Associates' office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority