**Flatirons Family Chiropractic**
Dr. Jacobe Holman, D.C.
300 Nickel Street, Ste. 9, Broomfield, CO 80020
Tel: 303-543-1400
Fax: 303-554-5834
www.flatironschiropractic.com

# Privacy Notice Form

## TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Notice of Privacy Practices for Protected Health Information of Flatirons Family Chiropractic will be provided upon my request. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, obtain payment for that treatment and to carry out health care operations of this chiropractic office. Flatirons Family Chiropractic has explained my right to obtain a copy of this Privacy Notice, and has encouraged me to read this Privacy Notice prior to signing this Consent.

2. Flatirons Family Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by Flatirons Family Chiropractic:

    a. A postcard mailed to me at the address provided by me;
    b. Telephoning my home, work, or cellular phone and leaving a message on my answering machine or with the individual answering the phone;
    c. E-mails and/or text messages, which you can unsubscribe from at any time.

4. I give Flatirons Family Chiropractic permission to discuss my protected health information with the following person(s):

    _____ _____
    Name Relationship

    _____ _____
    Name Relationship

5. Flatirons Family Chiropractic may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for Flatirons Family Chiropractic to conduct its specific health care operations.

6. I understand that I have the right to request that Flatirons Family Chiropractic restrict how may PHI is used and/or disclosed to carry out treatment, payment and/or health care options. However, Flatirons Family Chiropractic is not required to agree to any restriction that I have requested. If Flatirons Family Chiropractic agrees to a requested restriction, then the restriction is binding.

7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that Flatirons Family Chiropractic has already take action in reliance on this consent.

8. I understand that if I revoke this Consent at any time, Flatirons Family Chiropractic has the right to refuse to treat me.

9. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above in this Privacy Notice and contained in the enclosed Releases, the Flatirons Family Chiropractic will not treat me.

Patient's name (please print): _____ Date:_____

Patient's Signature: _____ Witness: _____
**(Parent or Guardian's signature if patient is under the age of 18)**