

**PULSE CHIROPRACTIC CLINIC
12325 SCARSDALE BLVD.
HOUSTON, TX 77089**

**PATIENT CONSENT FOR PURPOSES OF TREATMENT,
PAYMENT AND HEALTH CARE OPERATIONS**

I acknowledge that Pulse Chiropractic's Notice of Privacy 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 **Pulse Chiropractic Clinic**. I understand that I have the right to review the Notice of Privacy Practices prior to signing this document and the right to request restrictions as to how my health information may be used.

I understand that I may revoke this consent in writing, except in the instance **Pulse Chiropractic Clinic** has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, **Pulse Chiropractic Clinic** may refuse to treat me. I understand that **Pulse Chiropractic Clinic** reserves the right to change its Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by mail or in person.

Social Security Number _____

D/O/B _____

Patient Name (Print) _____ Date _____

Signature of Patient _____

Representatives Authorized to Act for Patient:

SPECIFIC HEALTH CARE AUTHORIZATION

The patient identified below authorizes **Pulse Chiropractic Clinic** to use and or disclose my Protected Health Information in accordance with the following:

- (1) I give permission to **Pulse Chiropractic Clinic** to use my address, phone number and clinical records to contact me with holiday cards, cards of other occasions and health-related information.
- (2) I give **Pulse Chiropractic Clinic** permission to treat me in an open room. Should I need to speak with the doctor in private, the doctor will provide this.

You have the right to revoke this authorization, in writing, at any time. However, your request to revoke this authorization is not effective to the extent that we have provided services or take action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Officer of **Pulse Chiropractic Clinic**. The written notice must contain your Name, Social Security number, date of birth, a clear statement of your intent to revoke this authorization, the date of your request and your signature. This revocation is not effective until it is received by the Privacy Officer.

This authorization is requested by **Pulse Chiropractic Clinic** for its own use/disclosure of PHI.

Patient Signature _____ Date _____