

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Tecumseh Neck & Back, Inc. has provided me with the “Notice of Privacy Practices.”

I understand I have a right to review the “Notice of Privacy Practices” of Tecumseh Neck & Back, Inc. prior to signing this document. The “Notice of Privacy Practices” for Tecumseh Neck & Back, Inc. is provided on request at the main administration desk of this practice. 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 healthcare operations of Tecumseh Neck & Back, Inc. “Notice of Privacy Practices” also describes my rights and the duties of Tecumseh Neck & Back, Inc. with respect to my protected health information.

Tecumseh Neck & Back, Inc. reserves the right to change the privacy practices that are described in the “Notice of Privacy Practices.” I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

PRINT Name of Patient or Personal Representative

Description of Personal Representative’s Authority