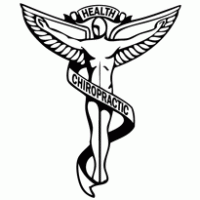
CAPITAL CHIROPRACTIC CENTER, P.C.

1732 Prospect Avenue / Helena, MT 59601/ Office: 406-449-7458 / Fax: 406-449-7496

HIPPA COMPLIANCE CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS.

Through the use of a consent form, CAPITAL CHIROPRACTIC CENTER, P.C. is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment, or health care operations. If you do not consent to this possible disclosure, this office may not be able to treat you without the needed information.
2. This notice contains office privacy practices. As a small provider organization, defined by the ASCA (Administrative Simplification Compliance Act), we are capable of sending claims electronically. The appointment desk may not be able to conceal the identity of the person checking in or making an appointment. The billing office is accessible to viewing as patients are taken to the treatment rooms. All other processes to protect your privacy are within our abilities and control.
3. This office reserves the right to change its privacy practice policy that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
4. You have the right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or health operations. This office is not required to agree to any restrictions that you have requested. If this office agrees to a requested restriction, then the restriction is binding on the office.
5. You have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.
6. A complete description of uses and/or disclosure necessary to carry out treatment, payment, and/or health care operations, is available for you to read if you desire to.
7. I hereby authorize the Physicians / Office Staff at Capital Chiropractic Center, P.C. to use and/or disclose health information for the purpose of filing my insurance claims and for billing purposes, and to authorize payments to be made directly to the provider of these services agreed upon to treatment under the provisions of Chiropractic Care Physician.

I have read and understand the foregoing notice, and all of my questions have been answered to the best of my knowledge and satisfaction in a way that is comprehensible to my understanding.

Name of Individual (please print) Legal Signature of Individual

Signature of Legal Representative (e.g. Attorney, Guardian, Parent to Minor) Relationship

/ /

Date Signed Witness