

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Consent of purposes of Treatment, Payment and Health Care Operations

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 Anthony J. Neary, DC. The Notice of Privacy Practices form is also provided in Dr. Neary's office. The Anthony J. Neary, DC LLC's Notice of Privacy Practices has been provided to me.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

This Notice of Privacy Practices also describes my rights and the duties of Anthony J. Neary, DC with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Dr. Anthony J. Neary for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Anthony J. Neary, DC.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operation of the practice. Anthony J. Neary, DC LLC is not required to agree to the restrictions that I may request. However, if Anthony J. Neary, DC LLC agrees to a restriction that I request, the restriction is binding on Dr. Anthony J. Neary.

Dr. Anthony J. Neary reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand I have a right to review Anthony J. Neary, DC LLC's Notice of Privacy Practices prior to signing this document. I may obtain a revised notice of privacy practices by calling the office and requesting the revised copy be sent in the mail or asking for one at the time of my next appointment.

I understand that diagnosis or treatment of me by Anthony J. Neary, DC may be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Anthony J. Neary has taken action in reliance on this consent.

Signature of Patient / Personal Representative

Date

Print name of Patient / Personal Representative

Description of Personal Representatives Authority