Chiropractic Center of Houston, PC
Brian Clemons, DC
930 Main Street Suite T-275
Houston, TX 77002

Acknowledgement of Receipt of Notice of Privacy Practices

As part of my health care, Chiropractic Center of Houston, PC creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication with Chiropractic Center of Houston's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Chiropractic Center of Houston that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that Chiropractic Center of Houston may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Chiropractic Center of Houston is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices and agree to the liability limitations explained therein.

___________________________________ _____________ _________________________
Signature of Patient or Legal Representative   Date   Relationship to Patient

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Printed Name of Patient