# LOCKPORT PAIN MANAGEMENT
# PRISM PERFORMANCE AND PHYSICAL THERAPY

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

_________________________________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the **right to change its privacy practices** that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following **appointment reminders** that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or **disclose my PHI** (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
6. It is the practice of this office to provide chiropractic care in an "**open-adjusting environment**". "Open Adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and ongoing routine details of care are discussed within earshot of other patients and staff. This environment also involves the therapy room and fitness center.
   We are requesting this authorization of you due to various interpretations under Federal Law with respect to what is known as an "Incidental Disclosures" of health information. It is our view that the kinds of matter related to an open adjusting environment are incidental matters. In the event you or someone else would not agree with us. We are providing this disclosure.
   The use of this format is intended to make your experience with our office more efficient and productive as well as enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Lockport Chiropractic or on your relationship with our staff.
7. **It is the practice of this office to take a photograph**(s) to use for patient files, posture programs and other assessment devices. These photographs will not be used for display purposes in the office without consent but may be sent to insurance companies as part of your medical records. It is up to the patient to inform Lockport Chiropractic if they do not want these photos included as part you're your medical record.
8. **It is the practice of this office to take video recordings** for training purpose only. These video recordings will not be used for display purposes in the office or be released to the public, but may be sent to practice management company (business associate) for training purposes. It is up to the patient to inform Lockport Chiropractic if they do not want these video recordings to be part of our training.
9. This **authorization may be revoked** by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.
10. I understand that **I have a right to request that the Practice restrict** how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

11. I understand that this Consent is **valid for seven years.** I further understand that I 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 the Practice has already taken action in reliance on this consent.
12. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
13. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

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| ______________________________<br>Name of Individual (Printed) | _________________________________<br>Signature of Individual |
| _______________________________<br>Signature of Legal Representative<br>(e.g., Attorney-In-Fact, Guardian, Parent if a minor)<br>Date Signed ____/____/____ | __________________________________<br>Relationship<br><br>Witness: _ |