EASTSIDE CHIROPRACTIC, P.C.
1011 WOODRIDGE LANE, BLDG 301
WATKINSVILLE, GEORGIA 30677
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DR. BRYAN HOOPER
DR. CHRIS LAMMERT
ASHLEY MCDONALD, LMT

PRIVACY POLICY

I, _____ (print name of patient) here by state that by the signing of this Consent, I acknowledge and agree to the following:

1. The Practice's Privacy Policy notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description for the uses and/or disclosure of my protected health information necessary to be treated and to obtain payment for treat me. The Practice explained to me that I have the right to obtain a copy of the privacy notice prior to signing this consent.
2. The practice reserves the right to change its privacy practices describe din the notice, in accordance with applicable law.
3. I understand that, and consent to, the practice calling or texting the contact numbers or emailing the provided address for appointment reminders. If calling, I agree for them to speak with the individual answering the phone. (initial in the box for the following you consent to)

☐ Permission to leave a message
☐ Permission to speak with the person answering the phone
☐ Permission to text the cell number on file

4. The Practice may use and/or disclose my protected health information for the practice to treat me and obtain payment for treatment rendered.
5. I understand that I have a right to restrict how my health information is used or disclosed to carry out treatment, obtain payment, or perform health care operations. The Practice is now required to agree to these written restrictions. If agreed, the Practice will be bound to these restrictions.
6. I understand that this policy is valid for **up to five years,** but the Practice can require a new policy be signed at any time. A New signature will be required if this policy is revised. I also understand that I can revoke consent in writing for all future transactions. It will not be retroactively applied.
7. **I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.**
8. **I understand that if I do not sign this policy 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 this policy and all my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Patient's signature (or legal guardian if minor) **Date**

_____
Print name of patient

Revised June 2019