ADVANCED BACK PAIN & INJURY CENTER
CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, _____(name of individual) consent to Advanced Back Pain & Injury Center ("the Practice's") use and disclosure of my Protected Health Information (PHI) for the purpose of providing treatment to me, for purposes related to the payment of services rendered to me, and for the Practice's general healthcare operations purposes (TPO). TPO shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, PHI means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health, or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

With this consent, Advanced Back Pain & Injury Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance and billing items, and any calls pertaining to clinical care.

With this consent Advanced Back Pain & Injury Center may mail to my home or other alternative location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practices duties regarding the types of uses and disclosures of my PHI.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian

_____ _____

Patient's Name | Date