

Consent For Treatment/ Consent for Treatment of a Minor:

I, the undersigned, hereby authorize Dr. Andrew L. Kemp, D.C., and whomever he may designate as his assistant to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I hereby give my consent for **KEMP CHIROPRACTIC CENTER** (herein after referred to as the "Practice") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at anytime.

With this consent, the Practice 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 items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice 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.

With this consent, the Practice may e-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. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Signature of Patient or Legal Guardian: \_\_\_\_\_  
If legal guardian, relationship to patient: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

**KEMP CHIROPRACTIC CENTER AND MRC TECHS**

I, \_\_\_\_\_ ("Patient") have read a copy of  
Kemp Chiropractic Center & MRC Techs's Notice of Patient Privacy Practices.

\_\_\_\_\_  
Signature of patient or parent or  
legal guardian

\_\_\_\_\_  
Date