BARTLETT
PAIN & WELLNESS CENTER

Cheryl Petschke, D.C.
Chiropractic Physician

158 Bartlett Plaza
Bartlett, IL 60103
(P) 630-830-2121
(F) 630-830-2195

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Patient's Name] consent to St. Charles Pain and Wellness Center, LLC ("the Practice's") to use and disclose my Protected Health information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purpose. Healthcare operations purpose 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, "Protected Health Information" 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 Protected Health information 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.

I understand I have a 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 Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician of the Practice has acted in reliance on this consent.

Patients Name:_____

Signature:_____Date:_____