C.A.F.E. of Life Chiropractic, Inc.
Alfonso Di Carlo, D.C.
2059 PA Route 309 * Allentown, PA 18104
(610) 366-1336

PATIENT CONSENT FORM - HIPAA

Our Notice of Privacy Practices provides information about how C.A.F.E. of Life Chiropractic, Inc. (the "Practice") may use and disclose protected health information ("PHI") about you. The Notice became effective on April 13, 2003, and contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Consent form. The terms of our Notice may change. As of November 13, 2006 we have changed our Notice(pf-hipaa-03310302), you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge and consent that our Practice may use and disclosure PHI about you for treatment, payment and health care operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form expires on 12/31/2090.

The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their PHI but the Practice does not have to agree to those restrictions.
- The Practice may display your name, and contact you via mail.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment and patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT for taking patient history procedures which are completed in a private, confidential setting. 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.

Patient Name:______________________________Signature: ______________________________

Date______________________________Witnessed by: ____________________________________
(Signature of Practice Representative)

Name of Parent/Guardian:(if signed by other than patient or minor):________________________

Relationship to Patient: ______________________________