CONSENT TO SERVICES

1. I____________________ authorize the performance upon my person the following procedure(s):

   ______Manipulation ______Examination
   ______Physical Medicine ______Other_________________________

2. In addition, I understand that other examination and treatment procedures may be necessary throughout the course of my admission and I understand that I will be so informed of the intent to perform and risks and benefits of the proposed procedures.
3. The nature and purpose of these procedures, possible alternatives, and the risks involved, the possible consequences and the possibility of complications have been sufficiently explained to me by clinic physicians and/or their designees.
4. I understand that there are charges for these procedures and that they will be explained to me by the finance department upon my request.

Signature:__________________________________ Date:_____________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________, (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Performance Wellness Centers, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

________________________ ____________________________________
Date Signature

____
Printed Name

AUTHORIZATION OF USE OR DISCLOSURE OF INFORMATION

I, hereby authorize Performance Wellness Center to (initial all that apply):

_____ Treat in an open adjustment/therapy room
_____ Send postcards for all occasions
_____ List your name in our newsletters
_____ Post your picture in our office
_____ Use of patient testimonial in reception area
_____ Use of patient testimonial on our webpage

This authorization shall be in forced and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand that information used or disclosed pursuant to this authorization, in writing, at any time by sending such written notification to Rae Doppman at 6500 N. Mopac Expressway Bldg 3, Ste 3101 Austin, Texas 78731. I understand that a revocation is not effective to the extent that Performance Wellness has relied on the use of disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Performance Wellness Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ Date_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Signature of Privacy Officer