St.Thomas Chiropractic & Wellness

Dr. Derek St. Thomas, DC, Cert. MDT

(646) 678-2225

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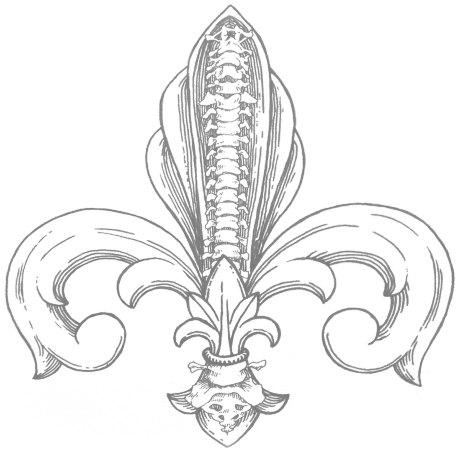

Consent Agreement

I, _____understand and accept that as part of my patient care with Dr. St. Thomas that his practice originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis, treatment, and any plans for future care or treatment as a standard of care. I understand that this information will be utilized for professional purposes to assist in developing an appropriate treatment plan and allow effective communication among other health care professionals who may participate in my care. This information will also be provided to third party payers that will include the diagnosis, procedures performed and documentation of those procedures that serve as verification of services rendered. Periodic re-evaluations will be performed to monitor my progress and assess whether appropriate care is being given to me.

I understand that I have the right to object to the use of my health information for purposes other than those described in this document. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. St.Thomas is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. St.Thomas has already taken action in reliance thereon.

I wish to add the following restrictions to the use or disclosure of my health information.

_____

_____

_____

I fully understand and accept the terms of this consent.

_____

Signature *Date*