GENERAL CONSENT FOR TREATMENT

☐ I, the undersigned, being either the patient or their legally authorized representative, do hereby consent to routine medical and osteopathic manipulative treatment and/or evaluation, including but not limited to laboratory and x- ray examinations.

_____
Signature of Patient / Guarantor

_____
Print Name of Patient and / or Guarantor

_____
Date

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

☐ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

☐ Obtain payment from third party payers (payment)

I acknowledge that I have had the opportunity to review your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand the practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by the restrictions.

_____
Signature of Patient / Guarantor

_____
Print Name of Patient and / or Guarantor

_____
Date

Heather A Sharkey, DO
60 Forest Falls Dr., suite 5
Yarmouth, ME 04096
(T) 207.847.9200 (F) 207.847.9315
www.heathersharkey.com