Consent for Purpose of Treatment, Payment and Health Care Operations

I acknowledge that Dr. Holly Donaldson's Notice of Privacy Practices has been provided to me.

I understand I have a right to review Dr. Holly Donaldson's Notice of Privacy Practices prior to signing this document. Dr. Holly Donaldson's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Holly Donaldson, D.C. The Notice of Privacy Practices for Holly Donaldson, D.C. is also provided on request at the main administrative desk of this practice and on the website of www.traversecitychiropractic.com. This Notice of Privacy Practices also describes my rights and Holly Donaldson's duties with respect to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Holly Donaldson's website, or calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of an appointment.

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Signature of Patient or Personal Representative Date

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Name of Patient or Personal Representative

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Description of Personal Representative Authority