Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **TROY NEUROPATHY CENTER, PLLC's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **TROY NEUROPATHY CENTER, PLLC's** Notice of Privacy Practices prior to signing this document and that **TROY NEUROPATHY CENTER, PLLC's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices 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 **TROY NEUROPATHY CENTER, PLLC.** The Notice of Privacy Practices for **TROY NEUROPATHY CENTER, PLLC** is also provided on request at the main administration desk of this practice. The Notice of Privacy Practices also describes my rights and **TROY NEUROPATHY CENTER, PLLC's** duties with respect to my protected health care information.

TROY NEUROPATHY CENTER, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Relationship to Patient