

Tri-County Clinic of Chiropractic

Patient Communications & Marketing Consent

Effective May 27, 2026

Patient Name: _____

Date of Birth: _____ Date: _____

Tri-County Clinic of Chiropractic is committed to communicating with you in the way you prefer and to using your information responsibly. Please review the consent options below and initial each item you agree to.

These options are optional. Declining any or all of them will not affect your ability to receive care at our clinic. You may withdraw any consent at any time by contacting our office at office@tricountychiroclinic.com or **(765) 896-5155**.

1. Appointment Communications

I consent to receive appointment reminders, scheduling messages, and care-related communications by email and SMS text message at the contact information I have provided. Message and data rates may apply. I understand I can reply STOP at any time to opt out of SMS messages.

Patient Initials: _____

2. Marketing Communications

I consent to receive newsletters, promotional offers, wellness tips, educational content, and other marketing communications from Tri-County Clinic by email and/or SMS.

Patient Initials: _____

3. Advertising Data Use

I consent to Tri-County Clinic using my contact information (name, email, phone number) in a securely hashed and encrypted format with advertising platforms such as **Google Ads** and **Meta (Facebook/Instagram)** for the purpose of delivering relevant advertisements and managing audience targeting. I understand that:

- **No information about my medical conditions, treatment, diagnoses, or appointments** will be shared.
- Only general contact information is used.
- My contact information is encrypted using SHA-256 hashing before being shared.
- I may withdraw this consent at any time by contacting the office.

Patient Initials: _____

Patient Acknowledgment

By signing below, I confirm that:

- I have read and understand each of the consent options above.
- I have initialed only those options I agree to.
- I understand that I may withdraw any consent at any time by contacting the office.
- I have been informed that Tri-County Clinic's **Notice of Privacy Practices** (HIPAA) governs my protected health information separately from this consent form.

Patient Signature

Date

Parent / Guardian Signature (if patient is a minor)

Date

Office Use Only

Received by: _____

Date scanned: _____

Entered in EHR: Yes No

Marketing list updated: Yes No