

“Our mission is to revolutionize the community’s expectations of health, human potential and pediatric development.”

Health Care Information Authorization

The following office procedures allow Chiropractic Solutions to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters relating to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters relating to care in this office.
- We routinely have mailings (including email) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- When you refer anyone to us, we would like to directly thank you and publicly thank you on the office bulletin board.
- We would like to be able to refer others to speak with you about your experience at Chiropractic Solutions.
- We often take and post photos of our practice members/patients in the office and in our newsletters

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Chiropractic Solutions.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

_____	_____	_____	_____
Patient Name Printed	Patient Name Signature	Office Representative	Date
_____	_____	_____	_____
Personal Representative Printed	Personal Representative Signature	Office Representative	Date

Privacy Notice Acknowledgement

We at Chiropractic Solutions are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Chiropractic Solution’s *Notice of Privacy Practices for Protected Health Information*.

_____	_____	_____	_____
Patient Name Printed	Patient Name Signature	Office Representative	Date