BACK 2 BACK CHIROPRACTIC
A Family Wellness Place

Patient Name: _____

Notice of Privacy Practices- HIPAA:

I ACKNOWLEDGE THAT I HAVE RECEIVED, REVIEWED, UNDERSTAND AND AGREE TO THE NOTICE OF PRIVACY PRACTICES OF BACK 2 BACK CHIROPRACTIC WHICH DESCRIBES THE PRACTICE'S POLICIES AND PROCEDURES REGARDING THE USE AND DISCLOSURE OF ANY OF MY PROTECTED HEALTH INFORMATION CREATED, RECEIVED, OR MAINTAINED BY THE PRACTICE.

Signature: _____ Date: _____

Consent Of treatment:

Signature: _____ Date: _____

Authorization to Release Medical Information:

Signature: _____ Date: _____

Authorization of Payment at time of Services Rendered:

Signature: _____ Date: _____

Understanding the Purpose of Chiropractic Care:

Signature: _____ Date: _____

Consent for Treatment of a Minor:

Signature: _____ Date: _____