Notice of Privacy Practices Acknowledgement Initial Uses Authorization Form

Joslyn Chiropractic Center

Effective: April 15, 2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Joslyn Chiropractic Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be place on display I the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Angela Howe.

Joslyn Chiropractic Center also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attaches. Marketing; internal referral board, testimonials, pictures on bulletin board or information unrelated to healthcare and other marketing materials. _____ (please initial)

If you have any questions regarding this notice or our health information privacy policies, please contact: Angela Howe Joslyn Chiropractic Center, 1044 Joslyn Ave, Pontiac, MI 48340, (248)332-0111

Your E-mail address: _____

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date: _____

Authorization

I certify that I have read and understand the patient information sheet to the best of my knowledge. The questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____