ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRATICES

Patient Name: _____

Date of Birth: _____

Social Security Number: _____ - _____ - _____

I acknowledge that this Practice has provided me with a written copy of the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy and ask questions.

Patient Signature: _____ Date: _____

Consent for Examination and Treatment

The undersigned patient, parent or legal guardian gives permission to treat any of our children in our absence should they require Medical/Chiropractic treatment and are brought in by other designated persons.

_____ _____

Signee Date

_____ _____

Witness / Notary Date