

**Advanced Health Chiropractic
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Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance and Portability Act of 1996 ("hippa") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we collected and will collect in the future.

To comply with one of HIPPA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a claim for payment of fees: a third party payer's examination of our records: a court order as part of a criminal investigation: an identification of a dead body: a licensure investigation: or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make referral to or consult with another chiropractor or other health care professionals, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordination your treatment.

Patient Acknowledgment

Please sign this form below under the heading "Patient Acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature

Patient Name (print)

Date

Patient refused to sign

The following circumstances prohibited the patient from signing the Acknowledgement:

 An emergency situation prevented the patient from signing the Acknowledgement:

Patient Consent:

Please sign this form below under the heading "Patient Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature

Patient Name

Date