Patient name:_____

1820 S. Westnedge Ave. Suite #1. Kalamazoo, MI 49008

269.344.5551 antoniottichiropractic.com

PERMISSIONS

I give permission for the person(s) listed below to receive the following information:

- ☐ Appointment type/time
- ☐ Account balances/financials
- ☐ Patient treatment; including supplements if applicable

Name:_____ Name:_____

- ☐ The above named may also change or cancel my appointments

These permissions do not expire, unless stated otherwise.

- ☐ Permissions expire on:_____

Patient Name (printed): _____

Patient Signature: _____

Witness Signature: _____

My minor child has permission to receive treatment in my absence.

Patient Name (printed): _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____

☐ OFFICE USE ONLY: MEMO ACCOUNT

CONSENT FOR PURPOSES OF TREATMENT/ PAYMENT & HEALTHCARE OPERATIONS

I acknowledge that Antoniotti Chiropractic Offices "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Antoniotti Chiropractic Offices Notice of Privacy Practices prior to signing this document. Antoniotti Chiropractic Offices Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Antoniotti Chiropractic Offices. The Notice of Privacy Practices for Antoniotti Chiropractic Offices is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Antoniotti Chiropractic Offices duties with respect to my protected health information.

Antoniotti Chiropractic Offices reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Personal Representative Date