

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.  
 We want your visit with us to be comfortable, helpful, and educational.

**confidential health information**

<b>1 PATIENT CONTACT</b>		clinic id	date
last name		first name	m.i.
preferred to be called			
street			
city		state	zip
home phone		mobile phone	
work phone		e-mail	

<b>2 PATIENT PERSONAL</b>		age	date of birth	social security #	sex	<input type="checkbox"/> male	<input type="checkbox"/> female
status		<input type="checkbox"/> single	<input type="checkbox"/> married	<input type="checkbox"/> partnered	<input type="checkbox"/> widowed	<input type="checkbox"/> separated	<input type="checkbox"/> divorced

<b>3 EMERGENCY CONTACT</b>		name	home phone
relationship		work phone	

<b>4 SPOUSE OR GUARDIAN</b>		last name	first name	m.i.
employer name				
work phone		date of birth	social security #	

<b>5 PATIENT EMPLOYMENT</b>		employer name	occupation
street			
city		state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

patient or guardian signature

date

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## confidential health information

<b>1 PATIENT INFORMATION</b>		clinic id	date	
last name		first name		m.i.
age	date of birth	social security #	sex	<input type="checkbox"/> male <input type="checkbox"/> female
Are you here because you were involved in a vehicle collision?			<input type="checkbox"/> yes	<input type="checkbox"/> no
Are you here because you were injured at your place of employment?			<input type="checkbox"/> yes	<input type="checkbox"/> no
Are you here because you were involved in another type of accident?			<input type="checkbox"/> yes	<input type="checkbox"/> no
Who is responsible for this account?				
Will you be using health insurance to supplement payment to our office*?			<input type="checkbox"/> yes	<input type="checkbox"/> no

\* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

<b>2 INSURANCE COVERAGE</b>				
type of insurance				
<input type="checkbox"/> employee group health plan	<input type="checkbox"/> personal health insurance	<input type="checkbox"/> health savings account	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
<input type="checkbox"/> personal injury	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> TRICARE/CHAMPUS	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> FECA
primary insurance company		primary ins ID#	primary ins group#	
secondary insurance company		secondary ins ID#	secondary ins group#	

<b>3 INSURED INFORMATION</b>		Are the insured and patient the same person? <input type="checkbox"/> yes <input type="checkbox"/> no		If YES, do not complete section 3.
last name		first name		m.i.
street				
city	state	zip		
age	date of birth	social security #	sex	<input type="checkbox"/> male <input type="checkbox"/> female
relationship to insured <input type="checkbox"/> spouse <input type="checkbox"/> dependent <input type="checkbox"/> Other _____				

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you - supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges before the associated procedure or service is performed
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered

patient or guardian signature

date

## 1 BENEFITS ASSIGNMENT

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

patient or guardian signature \_\_\_\_\_

date \_\_\_\_\_

## 2 INFORMATION RELEASE

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

patient or guardian signature \_\_\_\_\_

date \_\_\_\_\_

## INSURANCE VERIFICATION

OFFICE USE ONLY – Please Do Not Write In This Box

Is this a **Workers' Comp** case?  yes  no  
 Has the injury been reported?  yes  no  
 Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Is patient currently employed at place of injury?  yes  no  
 Name of person authorizing care: \_\_\_\_\_

Is this an **Auto Collision** or **Personal Injury** case?  yes  no  
 Has it been reported to the insurance company?  yes  no  
 Has an application for benefits been filed?  yes  no  
 Did the police write a report?  yes  no  
 Is auto or PI insurance primary?  yes  no  
 Agent name and contact info: \_\_\_\_\_

Does the plan cover the following services?

chiropractic adjustments	<input type="checkbox"/> yes	<input type="checkbox"/> no
modalities:		
hot/cold packs	<input type="checkbox"/> yes	<input type="checkbox"/> no
mechanical traction	<input type="checkbox"/> yes	<input type="checkbox"/> no
electric stimulation	<input type="checkbox"/> yes	<input type="checkbox"/> no
ultrasound	<input type="checkbox"/> yes	<input type="checkbox"/> no
therapeutic exercise and activities	<input type="checkbox"/> yes	<input type="checkbox"/> no
neuromuscular re-education	<input type="checkbox"/> yes	<input type="checkbox"/> no
massage	<input type="checkbox"/> yes	<input type="checkbox"/> no
manual therapy technique	<input type="checkbox"/> yes	<input type="checkbox"/> no
exams	<input type="checkbox"/> yes	<input type="checkbox"/> no
supports, braces, collars	<input type="checkbox"/> yes	<input type="checkbox"/> no
pillows	<input type="checkbox"/> yes	<input type="checkbox"/> no
nutritional supplements	<input type="checkbox"/> yes	<input type="checkbox"/> no
orthotics	<input type="checkbox"/> yes	<input type="checkbox"/> no
other: _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
other: _____	<input type="checkbox"/> yes	<input type="checkbox"/> no

Does the plan have a deductible?  yes  no  
 Amount for an individual: \_\_\_\_\_  
 Amount for the family: \_\_\_\_\_  
 Amount currently met: \_\_\_\_\_  
 When does the deductible renew? \_\_\_\_\_  
 Do charges for diagnostic tests apply to the deductible? \_\_\_\_\_

What is the co-pay after the deductible is met? \_\_\_\_\_

What is the maximum yearly benefit? \_\_\_\_\_

What is the yearly visit cap? \_\_\_\_\_

Does the company assign benefits to the doctor?  yes  no

Are any special forms required to file claims?  yes  no

What is the name of the person that you spoke with?

Last: \_\_\_\_\_  
 First: \_\_\_\_\_  
 ID# \_\_\_\_\_ Extension: \_\_\_\_\_

Notes: \_\_\_\_\_

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<b>1</b> PATIENT INFORMATION	clinic id	date	
	last name	first name	m.i.

### 2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident?  yes  no

What services interest you? (mark all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> injury prevention                                 | <input type="checkbox"/> treatment for pain                 | <input type="checkbox"/> patient education classes             |
| <input type="checkbox"/> balance and coordination training                 | <input type="checkbox"/> spinal and body alignment          | <input type="checkbox"/> body composition counseling           |
| <input type="checkbox"/> range of motion, mobility, or flexibility therapy | <input type="checkbox"/> strengthening and stamina exercise | <input type="checkbox"/> nutritional and supplement counseling |
| <input type="checkbox"/> other: _____                                      |   |  |

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel?  dull/achy  sharp  numb  tingling  burning  cold

How often do you experience the **primary** complaint?  constantly  daily  weekly  monthly  yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

<b>1</b> no pain or discomfort	<b>2</b> slight discomfort	<b>3</b> pain that does not affect my activity	<b>4</b> pain that affects my daily activities	<b>5</b> pain that prevents performing my daily activities	<b>6</b> pain that limits my work schedule	<b>7</b> pain that prevents working at all	<b>8</b> pain that prevents working and all personal activity	<b>9</b> pain that keeps me bed ridden	<b>10</b> pain that causes thoughts of suicide
--------------------------------	----------------------------	--	--	--	--	--	---	--	--

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

2	4
3	5

Do you have any other condition other than what brings you here?  yes  no

If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.



### 3 LIFESTYLES & HABITS

patient name

How many hours of television do you watch a day?  < 1  1-3  3-5  >5

Do you usually snack while watching television?  yes  no

How many hours per day do you use a computer at work or home?  < 1  1-3  3-5  >5

How many hours per day do you ride in a car or other vehicle?  < 1  1-3  3-5  >5

How often do you exercise?  daily  3x's/week  2x's/week  1x/week  I don't exercise

How long do your exercise work outs last?  >1 hour  1 hour  30 minutes  < 30 minutes  NA

What are your exercise activities? (mark all that apply)  I don't exercise

walking  swimming  weight lifting

stretching/flexibility  yoga/Pilates  resistance bands

running/treadmill/rowing/climbing  group exercise classes  other \_\_\_\_\_

Do you take a multi-vitamin?  yes  no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

How often do you use tobacco?  never  daily  weekly  monthly  yearly

How many servings of alcohol do you drink each week?  0  1-2  3-5  >5

How many servings of coffee do you drink each week?  0  1-2  3-5  >5

How many servings of soda do you drink each week?  0  1-2  3-5  >5

### 4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
heart problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
kidney problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
cancer	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
headaches	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
back pain	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
obesity	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
poor conditioning	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister

### 5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no	epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	low back pain	<input type="checkbox"/> yes <input type="checkbox"/> no	polio	<input type="checkbox"/> yes <input type="checkbox"/> no
anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	goiter	<input type="checkbox"/> yes <input type="checkbox"/> no	measles	<input type="checkbox"/> yes <input type="checkbox"/> no	rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no
appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	mental disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV positive	<input type="checkbox"/> yes <input type="checkbox"/> no	mumps	<input type="checkbox"/> yes <input type="checkbox"/> no	venereal infection	<input type="checkbox"/> yes <input type="checkbox"/> no
cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	influenza	<input type="checkbox"/> yes <input type="checkbox"/> no	pleurisy	<input type="checkbox"/> yes <input type="checkbox"/> no	whiplash	<input type="checkbox"/> yes <input type="checkbox"/> no
				pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	whooping cough	<input type="checkbox"/> yes <input type="checkbox"/> no

## 6 INJURIES

patient name

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

## 7 HOSPITAL / MEDICINE

Have you had breast implant surgery?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Have you had knee or hip replacement surgery?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have a pacemaker?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have any other implantable medical devices in your body?	<input type="checkbox"/> yes	<input type="checkbox"/> no

Mark all of the following procedures as they pertain to you.						rectal surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
vaccinations	<input type="checkbox"/> yes	<input type="checkbox"/> no	tubes in ears	<input type="checkbox"/> yes	<input type="checkbox"/> no	sinus surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
tonsillectomy	<input type="checkbox"/> yes	<input type="checkbox"/> no	appendectomy	<input type="checkbox"/> yes	<input type="checkbox"/> no	hernia surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
gall bladder removal	<input type="checkbox"/> yes	<input type="checkbox"/> no	female/male surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	thyroid surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
back surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no				stomach surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory?  yes  no      Were you ever knocked unconscious?  yes  no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection?  yes  no

Mark the following conditions that are **currently** a cause of significant concern for you.

**General**

<input type="checkbox"/> consistent fainting	<input type="checkbox"/> chills	<input type="checkbox"/> convulsions	<input type="checkbox"/> depression	<input type="checkbox"/> dizziness
<input type="checkbox"/> loss of weight	<input type="checkbox"/> fatigue	<input type="checkbox"/> fever	<input type="checkbox"/> headache	<input type="checkbox"/> loss of sleep
<input type="checkbox"/> weight gain	<input type="checkbox"/> neuralgia	<input type="checkbox"/> night sweats	<input type="checkbox"/> wheezing	<input type="checkbox"/> nervousness

**Gastro-Intestinal**

<input type="checkbox"/> constipation	<input type="checkbox"/> diarrhea	<input type="checkbox"/> gall bladder problems	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> jaundice
<input type="checkbox"/> liver problems	<input type="checkbox"/> nausea	<input type="checkbox"/> stomach pain	<input type="checkbox"/> poor appetite	<input type="checkbox"/> poor digestion
<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> vomiting	<input type="checkbox"/> vomiting blood		

**Eye/Ear/Nose/Throat**

<input type="checkbox"/> asthma	<input type="checkbox"/> crossed eyes	<input type="checkbox"/> deafness	<input type="checkbox"/> earache	<input type="checkbox"/> ear discharge
<input type="checkbox"/> ear noises	<input type="checkbox"/> enlarged thyroid	<input type="checkbox"/> frequent colds	<input type="checkbox"/> hay fever	<input type="checkbox"/> hoarseness
<input type="checkbox"/> nasal obstruction	<input type="checkbox"/> nose bleeds	<input type="checkbox"/> pain in eyes	<input type="checkbox"/> poor vision	<input type="checkbox"/> sinusitis
<input type="checkbox"/> sore throat	<input type="checkbox"/> tonsillitis			

**Respiratory**

<input type="checkbox"/> chest pain	<input type="checkbox"/> chronic cough	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> spitting blood	<input type="checkbox"/> spitting phlegm
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**Muscles/Joints/Bones**

<input type="checkbox"/> backache	<input type="checkbox"/> foot problems	<input type="checkbox"/> pain bet. shoulders	<input type="checkbox"/> painful tailbone	<input type="checkbox"/> stiff neck
<input type="checkbox"/> spinal curvature	<input type="checkbox"/> swollen joints	<input type="checkbox"/> tremors	<input type="checkbox"/> twitching	<input type="checkbox"/> weakness

**Cardio-Vascular**

<input type="checkbox"/> ankle swelling	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> heart trouble	<input type="checkbox"/> pain over heart
<input type="checkbox"/> poor circulation	<input type="checkbox"/> rapid heart	<input type="checkbox"/> slow heart	<input type="checkbox"/> strokes	

**Skin or Allergies**

<input type="checkbox"/> bruise easily	<input type="checkbox"/> dryness	<input type="checkbox"/> eczema	<input type="checkbox"/> hives	<input type="checkbox"/> itching
<input type="checkbox"/> sensitive skin				

**Women**

<input type="checkbox"/> cramps	<input type="checkbox"/> excessive flow	<input type="checkbox"/> hot flashes	<input type="checkbox"/> irregular cycle	<input type="checkbox"/> painful periods
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**9 PREGNANCY**

**WOMEN ONLY**

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant?  yes  no      On what date did your last period begin?

Do you want to take a pregnancy test now?  yes  no      **OFFICE USE ONLY**  
result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

tubal ligation	<input type="checkbox"/> yes <input type="checkbox"/> no	complete or partial hysterectomy	<input type="checkbox"/> yes <input type="checkbox"/> no	partner had a vasectomy	<input type="checkbox"/> yes <input type="checkbox"/> no
less than 10 days since the start of my last period	<input type="checkbox"/> yes <input type="checkbox"/> no	taking birth control pills	<input type="checkbox"/> yes <input type="checkbox"/> no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

## Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

### We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

### We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

### You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

**These privacy practices are effective:** \_\_\_\_\_

**For further information please contact:** \_\_\_\_\_

## Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

## Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

## Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

\_\_\_\_\_  
patient or guardian signature

\_\_\_\_\_  
date