Amosson Chiropractic
3510 Kimball Avenue, Suite B
Waterloo, IA 50702

FORM: NOTICE OF PRIVACY PRACTICE SUMMERY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Amosson Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Amosson Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Amosson Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Amosson Chiropractic will never share your information unless you give written permission for marketing purposes, most sharing of psychotherapy notes, nor the sale of your health information.

Amosson Chiropractic may use or share your information for health research. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Amosson Chiropractic may disclose you information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to Dr. Kelly Amosson and the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Amosson Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

If you have any questions or complaints please contact Dr. Kelly Amosson at 319-236-2737

_____ _____

Patient Signature Date

Authorization for Chiropractic Care

I consent to recommendations and care by Dr. Amosson for myself (or my children if minors) which may include, but are not limited to examinations, x-rays, chiropractic adjustments, physiotherapy, and rehabilitative procedures. I understand that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur including minor aggravation of current condition, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including stroke, and death. I am signing this consent after having been full informed to my satisfaction by Dr. Amosson and /or her staff of the risks and benefits of the care, and the risks and benefits of not having the recommended treatment. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Dr. Amosson and/or her staff.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE AMOSSON CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Name:_____

Signature:_____Date:_____Witnessed: _____Date:_____