O'BRIEN CHIROPRACTIC

COMBINED ACKNOWLEDGMENT & CONSENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This acknowledgment of notice and consent authorizes Dr. Philip A. O'Brien, DC to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices

Dr. Philip A. O'Brien, DC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date if the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail 95 Highland Avenue Suite 140
Bethlehem, PA 18017
Telephone 484-892-2420
Fax 610-419-7177

ACKNOWLEDGMENT AND CONSENT *Print or type all information except signature*

I have received the Notice of Privacy of Dr. Philip A. O'Brien, DC and authorize them to use and disclose health information about

_____(Patient Name) for treatment, payment, and healthcare operations purposes

consistent with its Notice of Privacy Practices.

Signature of responsible party _____ Date _____/_____/_____

Name of responsible party _____ Relationship_____

It is the office policy of Dr. Philip A. O'Brien, DC and its staff not to release confidential and/or unauthorized information by any means. Whenever returning telephone calls and the answering system picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information beyond our identification and return contact numbers will not be left with an answering system.

I authorize Dr. Philip A, O'Brien, DC and/or their staff to contact me and leave contact information message at the following numbers:

PLEASE PROVIDE THE APPROPRIATE NUMBERS IN THE SPACES PROVIDED BELOW.
PLEASE CHECK *ONE* PRIMARY CONTACT NUMBER, THE NUMBER YOU WISH FOR US TO CALL FIRST

❍ Home Telephone _____

❍ Work Telephone _____

❍ Cell Phone_____

If you would like to have information released to someone other than yourself, please complete the following:

Please list the names and contact number for anyone that you authorize:

Spouse_____ Number_____

Parent _____ Number_____

Other names (please list relationship, such as fiance, boyfriend/girlfriend, sibling, etc.)

Name _____ Relationship _____ Number_____

Name _____ Relationship _____ Number_____

Name _____ Relationship _____ Number_____

Signature of responsible party _____ Date _____/_____/_____

Please print name of responsible party legibly_____

Please print Patient's name legibly (if different from above) _____