

APPOINTMENT REMINDERS, MARKETING MATERIALS AND HEALTH CARE INFORMATION AUTHORIZATION

Appointment reminders: Your chiropractic physician and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

Cell phone () _____ so that we may leave a message and/or a text.

Email Address: _____. By signing this form, you are giving us authorization to contact you with these reminders and information.

Marketing information: From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. *Marketing is strictly handled in-house, and at no point will your information be outsourced.* We are specifically requesting authorization to market the following products and/or services to you. Patient Appreciation Day Specials, office newsletter, cards, i.e., *Thank you, Welcome to our Clinic or Holidays.* In addition, special patient holiday promotion, Toys for Tots, Food Drive and/or charity collections.

You have the right to refuse to give us authorization to contact you about your appointment, and/or to inform you about health care marketing updates.

If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of 4/1/03. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above.

Patient Name Printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.