5446 N. Academy Blvd. Suite 102
Colorado Springs, CO 80918
Tel: (719) 594-0071 Fax: (719)260-1964

By my signature, I acknowledge that I have received a copy of the Notice of Privacy Practice from Springs Family Chiropractic.

Name of Patient (Please Print): _____

Patient and/or Guardian Signature: _____

Relationship to Patient: _____

Date: _____

In caring for our patients, it may be necessary for Springs Family Chiropractic staff to contact you by phone. When a patient is unavailable, we like to leave messages whenever possible.

Please review the information below and carefully consider whom you choose to have access to your medical information such as exams, labs, radiology results, appointments, and insurance or billing information. Please check the applicable ways for us to reach you and leave information.

☐ Voicemail/Answering machine
☐ Office/Work voice mail
☐ Spouse (name): _____
☐ Guardian (name):_____
☐ Other (please specify):_____

Denial

☐ I, _____, wish to be contacted personally and do not authorize Springs Family Chiropractic to leave messages with another person.

You have the option to change your contact preferences at any time by completing an updated contact information form.

_____
Printed Name

_____ _____
Signature Date

_____
Relationship to patient if minor