

COMPLETE HEALTH CHIROPRACTIC CENTER, LLC

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I understand that Complete Health Chiropractic Center, LLC, Sharmel Bone, LMT, Jennifer Davis, LMT, and Staff (referred to below as "The Practice") will use and disclose health information about me.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Privacy Notice To Patients and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Privacy Notice To Patients may be revised from time to time, and that I am entitled to receive a copy of any revised Privacy Notice To Patients. I also understand that a copy or a summary of the most current version to this Practice's Privacy Notice To Patients in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Privacy Notice To Patients, and I understand that This Practice is not required by law to agree to such requests.

Clinic Protocol

Appointment reminders *may* be called to the patient's home phone prior to the appointment date. If a message is left, no confidential information will be given.

Test Results:

- * The clinic doctors reserve the right to discuss patient results and issues with family members if deemed necessary.
- * If the clinic staff is unable to contact the patient by phone, results *may* be mailed to the patient's home.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Privacy Notice To Patients.

By: _____ (Patient)	Date: _____
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-OR-

By: _____ (Patient representative)	Date: _____
Description of Representative's Authority: _____	