

**Darnell Chiropractic
300 Nickel Street Suite 9
Broomfield, CO 80020**

SUMMARY TAKEN FROM: NOTICE OF PRIVACY PRACTICES

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

Darnell 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 your care that you receive.

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

You may complain to Dr. James R. Darnell and to 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.

Darnell 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.

If you have any questions or complaints please contact: Dr. James R. Darnell at 303-543-1400.

Patient Signature: _____

Date: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself Furthermore. I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____

Date: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case.

Patient (or Guardian) Signature: _____

Date: _____