ZELLNER
chiropractic center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENTS RIGHTS FORM.

You have the right to refuse to sign this document.

I, _____, have received a copy of Zellner Chiropractic Center's Notice of Privacy Practices and Patient Rights form.

_____ _____
Signature Date

Please continue on back

FOR OFFICE USE ONLY

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____
  _____

1310 Alpine Avenue | Boulder, Colorado | 80304 | 303-444-7524 | fax: 303-444-2464
info@zellnerchiropractic.com | www.zellnerchiropractic.com

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AUTHORIZATION FOR PATIENT CONTACT

We are a community-oriented and wellness based practice dedicated to promoting optimal health and wellness. It is the desire of our staff to use your contact information for the following reasons listed below. If you choose not to authorize the use of your information in this manner, your decision will have no adverse effect on your relationship with Zellner Chiropractic Center.

We would like your permission to contact you for the following reasons:

- Appointment changes, reminder phone calls, or missed appointments
- Discussing your care with you
- Health information including Health Care Classes and periodic newsletters
- Annual holiday and birthday cards
- Payment or billing statements

Name (Printed):_____

Signature:_____

Date:_____

Your signature authorizes us to contact you for these reasons, complying with any exclusions you have made above.

*This authorization may be revoked by you at any time by advising our office in writing. Please allow processing time for the change in our system.

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