CHIROLOVE
SPINE & WELLNESS
CENTER

PATIENT INFORMATION

DATE: _____ SSN (NOT REQUIRED): _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL#: _____ HOME#: _____

EMAIL: _____

ARE YOU OKAY WITH TEXT/EMAIL REMINDERS? ☐ YES ☐ NO

GENDER AT BIRTH: ☐MALE ☐FEMALE

GENDER PRESENTLY IDENTIFIED: ☐MALE ☐FEMALE

DATE OF BIRTH: _____ AGE: _____

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

OCCUPATION: _____

PATIENT EMPLOYER: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

BEST CONTACT NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

HOW DID YOU HEAR FROM US? ☐ GOOGLE ☐WEBSITE ☐WALK-IN

☐MAGAZINE ☐SOCIAL MEDIA ☐OTHER: _____

ARE YOU INTERESTED IN WEIGHT-LOSS? ☐ YES ☐ NO

INSURANCE INFORMATION

SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

INSURANCE COMPANY: _____

ID NUMBER: _____

ARE YOU COVERED BY ANY OTHER INSURANCE? ☐ YES ☐ NO

SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

INSURANCE COMPANY: _____

ID NUMBER: _____

ASSIGNMENT & RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH MY INSURANCE COMPANY (IES) AND ASSIGN DIRECTLY TO **CHIROLOVE SPINE & WELLNESS CENTER** ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSION.

THE ABOVE-NAMED FACILITY CAN USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY (IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____

PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____

DATE **RELATIONSHIP TO PATIENT**

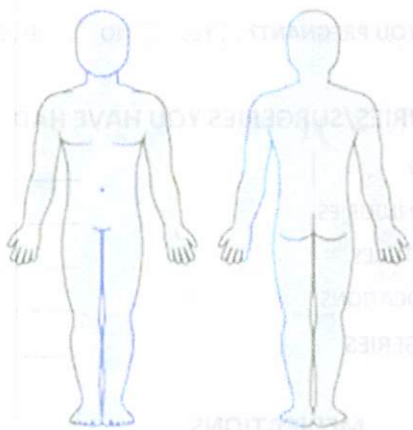
PATIENT CONDITION

REASON FOR VISIT? _____

WHEN DID YOUR SYMPTOMS APPEAR? _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ☐ YES ☐ NO ☐ UNKNOWN

MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING.



RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (SEVERE PAIN) _____

TYPE OF PAIN: ☐ SHARP ☐DULL ☐THROBBING ☐ NUMBNESS ☐ ACHING ☐ SHOOTING

☐ BURNING ☐ TINGLING ☐ CRAMPS ☐STIFFNESS ☐ SWELLING

HOW OFTEN DO YOU HAVE THIS PAIN? _____

IS IT CONSTANT OR DOES IT COME AND GO? _____

DOES IT INTERFERE WITH? ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ RECREATION

ACTIVITIES OR MOVEMENT THAT ARE PAINFUL TO PERFORM: ☐ SITTING ☐ STANDING ☐ WALKING ☐ BENDING ☐ LYING DOWN

HOBBIES/INTERESTS: _____

DOUBLE-SIDED

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION?

☐ MEDICATION ☐ SURGERY ☐ PHYSICAL THERAPY ☐ CHIROPRACTIC SERVICES ☐ NONE ☐ OTHER: _____

DATE OF LAST: PHYSICAL EXAM _____ SPINAL X-RAY _____ CHEST X-RAY _____

SPINAL EXAM _____ MRI, CT-SCAN, BONE SCAN _____

PLEASE CHECK THE FOLLOWING SYMPTOMS YOU NOW HAVE OR HAVE HAD PREVIOUSLY:

GENERAL
- ☐ ALLERGY
- ☐ CHILLS
- ☐ CONVULSIONS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ FATIGUE
- ☐ FEVER
- ☐ HEADACHE
- ☐ LOSS OF SLEEP
- ☐ LOSS OF WEIGHT
- ☐ NERVOUSNESS/DEPRESSION
- ☐ SWEATS
- ☐ TREMORS

CARDIO-VASCULAR
- ☐ CHEST PAIN
- ☐ HARDENING OF ARTERIES
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ POOR CIRCULATION
- ☐ RAPID HEART BEAT
- ☐ SLOW HEART BEAT

RESPIRATORY
- ☐ CHRONIC COUGH
- ☐ DIFFICULT BREATHING
- ☐ SPITTING UP BLOOD
- ☐ SPITTING UP PHLEGM
- ☐ WHEEZING

GASTRO-INTESTINAL
- ☐ BELCHING/GAS
- ☐ COLON TROUBLE
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ DIFFICULT DIGESTION
- ☐ DISTENSION OF ABDOMEN
- ☐ EXCESSIVE HUNGER
- ☐ GALL BLADDER TROUBLE
- ☐ HEMORRHOIDS
- ☐ INTESTINAL WORMS
- ☐ JAUNDICE
- ☐ LIVER TROUBLE
- ☐ NAUSEA
- ☐ PAIN OVER STOMACH
- ☐ POOR APPETITE
- ☐ VOMITING
- ☐ VOMITING OF BLOOD

GENITO-URINARY
- ☐ BED WETTING
- ☐ BLOOD IN URINE
- ☐ FREQUENT URINATION
- ☐ KIDNEY INFECTION
- ☐ PAINFUL URINATION
- ☐ PROSTATE TROUBLE
- ☐ PUS IN URINE
- ☐ UNCONTROLLABLE KIDNEYS

MUCLE & JOINT
- ☐ CLICKING JAW
- ☐ LOW BACK PAIN
- ☐ MUSCLE SPASMS
- ☐ NECK PAIN/ STIFFNESS
- ☐ PAIN BETWEEN SHOULDERS
- ☐ PAIN/NUMBNESS IN:
- ☐ SHOULDERS
- ☐ ARMS
- ☐ ELBOWS
- ☐ HANDS
- ☐ HIPS
- ☐ LEGS
- ☐ KNEES
- ☐ FEET
- ☐ PAINFUL TAILBONE
- ☐ POOR POSTURE
- ☐ SCIATICA
- ☐ SPINAL CURVATURE
- ☐ SWOLLEN JOINTS

SKIN
- ☐ BOILS
- ☐ BRUISE EASILY
- ☐ COLD SORES
- ☐ DRYNESS
- ☐ RASHES/HIVES
- ☐ VARICOSE VEINS

EYE – EAR – NOSE –THROAT
- ☐ COLDS
- ☐ CROSSED EYES
- ☐ DEAFNESS
- ☐ EARACHE
- ☐ EAR DISCHARGE
- ☐ EAR NOISES
- ☐ ENLARGED GLANDS
- ☐ EYE DISCHARGE
- ☐ EYE PAIN
- ☐ FAILING VISION
- ☐ FARSIGHTEDNESS
- ☐ GUM TROUBLE
- ☐ HAY FEVER
- ☐ HOARSENESS/LARYNGITIS
- ☐ NASAL OBSTRUCTION
- ☐ NEARSIGHTEDNESS
- ☐ NOSE BLEEDS
- ☐ SINUS TROUBLE
- ☐ SORE THROAT

WOMEN ONLY
- ☐ CONGESTED BREASTS
- ☐ CRAMPS/BACKACHE
- ☐ EXCESSIVE FLOW
- ☐ HOT FLASHES
- ☐ IRREGULAR CYCLE
- ☐ LUMPS IN BREASTS
- ☐ MENOPAUSAL SYMPTOMS
- ☐ PAINFUL MENSTRUATION
- ☐ VAGINAL DISCHARGE

EXERCISE
- ☐ NONE
- ☐ MODERATE
- ☐ DAILY
- ☐ HEAVY

WORK ACTIVITY
- ☐ SITTING
- ☐ STANDING
- ☐ LIGHT LABOR
- ☐ HEAVY LABOR

HABITS
- ☐ SMOKING — PACKS/DAY _____
- ☐ ALCOHOL — DRINKS/WEEK _____
- ☐ COFFEE/CAFFEINE DRINKS — CUPS/DAY _____
- ☐ HIGH STRESS LEVELS — REASON _____

ARE YOU PREGNANT? ☐ YES ☐ NO **DUE DATE?** _____

INJURIES/SURGERIES YOU HAVE HAD:	DESCRIPTION	DATE:
FALLS		
HEAD INJURIES		
FRACTURES		
DISLOCATIONS		
SURGERIES		

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

HIPAA Notice of Privacy Practices

ChiroLove Spine & Wellness

1255 Paterson Plank RoadSecaucus, NJ 07094-3247

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our Office at

(201) 293-4697

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's
privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.
To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)In an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

ChiroLove Spine & Wellness Center

Patient Name: _____
Patient D.O.B.: _____

Informed Consent for Chiropractic Services

I have been informed of the following:

1. I have been informed that the process of rendering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table assist, or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
2. I have been informed that in addition to the rendering of the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
3. I have been informed that coinciding with the process, but not necessarily a result of, a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; occasional aggravation of presenting symptoms; rarely tissue bruising and/or swelling; rarely joint/bone separation/fracture (most noted are ribs); very rarely, disc and/or nerve injury; or extremely rarely, vascular injury to include stroke;
4. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from the complaint(s) location(s);
5. I have been informed that certain techniques may require close physical proximity between clinician and patient;
6. I have been informed that it is my responsibility to inform the chiropractor of any condition(s) that would otherwise not come to their attention;
7. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations;
8. I have been informed that the chiropractor has made no guarantee of a positive outcome from treatment;
9. I understand the clinical necessity of having these procedures and in so doing I release the doctor from any known potential damage and responsibility; and
10. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I **consent** to the performance of diagnostic and therapeutic procedures present and future that may be deemed reasonable and necessary by the doctor and/or staff under the direction and supervision of the office chiropractor(s) involved in my case.

Patient Signature:_____ **Date:**_____

Other Authorizing Name (if applicable):_____

Other Authorizing Relationship (if applicable):_____

Other Authorizing Signature (if applicable):_____

Witness Name:_____

Witness Signature:_____

Chirolove Spine & Wellness Center

Patient Name: _____ **D.O.B.:** _____

RADIOLOGY CONSENT

I have been explained the recommended radiology procedures, the potential risks and options. I understand the clinical necessity of having x-rays taken at this time and give my consent/permission for this procedure. In so doing I release the Doctor from responsibility, known and unknown, for potential damage arising from this procedure.

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I again understand the clinical necessity of having x-rays taken at this time and give my consent/permission for this procedure. At the present time (please check one):

_____ I am sure that I am not pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

_____ _____

Patient Signature **Date**

_____ _____

Witness Printed Name **Witness Signature**

ChiroLove Spine & Wellness Center

Payment Policy

PATIENTS WITH INSURANCE COVERAGE WE PARTICIPATE WITH:

Each plan we participate with varies by employer and/or insured. Please know your plan. Co-payments will be due and payable at the time the services are rendered. Deductibles and/or other balances that are your responsibility will be billed to you once that amount is determined.

PATIENTS WHO ARE NOT COVERED BY INSURANCE:

We require payment in full and/or in a monthly breakdown at the time services are rendered. Payment plan will be determined and card on file policy will apply. Card on file policy states that any patient taking care of a monthly payment plan, even if payments are being taken care of with cash or checks will need to provide us with a debit or credit card to keep on file.

In the event that any balance which may become due hereunder is referred to an attorney for collection, you agree to pay all costs of collection including an attorney's fee equal to 35% of the unpaid balance due, which amount you agree to be reasonable. You authorize the release of any information, including medical information, to determine liability for payment, process claims, and to obtain reimbursement for services rendered to you.

I have read and understand the payment policy outlined above and agree to all of the terms contained therein.

_____ _____

Print Patient's Name **Date**

_____

Patient's Signature

Patient Messaging/Email Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____

Print Patient's Name **Date**

_____

Patient's Signature