



**TIERNEY  
CHIROPRACTIC**

6805 Flying Cloud Drive  
Eden Prairie, MN 55344  
952-833-3038 Phone  
952-833-3040 Fax

**Patient Information:**

Last Name:		First Name:		MI:
Address:			Apt/Suite #:	
City:	St:	Zip	Date of Birth:	
Marital Status:    Single    Married    Other		Sex:    M    /    F	Social Sec. #(SSN):	
Home Phone:		Employer:		
Work Phone:		Occupation:		
Cell Phone:		Email Address:		
Name of Emergency Contact:				
Emergency Contact Phone #:			Relationship to Emergency Contact:	
How did you hear about us?				

If you intend to use insurance, please be sure to present your insurance card to the receptionist – OR – complete the information below..

Primary Insurance Name and Address:	
Policy #:	Group #:
Primary Insured Name:	
Primary Insured Phone #:	Primary Insured DOB
Relation to Primary Insured:	SSN:
Primary Insured Employer	

**Authorization** – I hereby authorize Tierney Chiropractic (TC) to examine and treat my condition. TC has the right to release any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to TC. I authorize TC to initiate deemed complaints to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, **I am ultimately responsible for the balance of my account for any professional services rendered**, and I understand that I will be charged at a 6% annual percentage rate on any non-contract insurance balances over 90 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged \$30.00 for each returned check. While TC will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be adjusted to self-pay and due in full. I certify this information in true and correct to the best of my knowledge.

Signature

Date

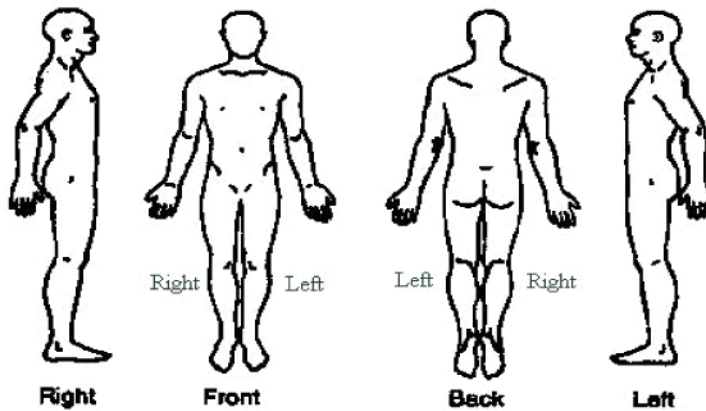
# Chief Complaint (your current presenting condition)

Describe your current injury or your current problem, if any: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

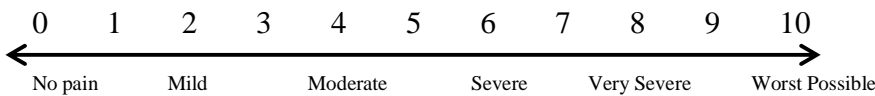
Please mark/draw your symptoms on the diagram:

- Aching - XXX
- Burning - ###
- Numbness - ///
- Pins/Needles - 000
- Stabbing - ●●●



**Doctor Use Only:**

Rate your pain right now (mark as "O"); average pain level (mark as "X")



Is your condition due to a recent accident or a recent injury?  Yes  No

If Yes, what type;  Worker's Comp  Motor Vehicle Accident  Sports Injury  Slip & Fall  
(or other) \_\_\_\_\_

When did your complaints and/or symptoms begin? \_\_\_\_\_

What helps/alleviates this condition? \_\_\_\_\_

What aggravates this condition? \_\_\_\_\_

Have you sought alternative or medical care for this specific condition?  Yes  No If yes,

\_\_\_\_\_

How do you want us to handle your current problem? (Check)

- Temporary/Relief Care – Treat the problem to reduce the symptom (with the problem likely to return)
- Stabilization Care – Treat the problem until the issue has stabilized and is improved
- Wellness Care - (Schedule Regular and on-going “tune-ups” for true preventative care)
- I would prefer to have Dr. Tierney discuss these options with me.

# Chief Complaint (your current presenting condition)

Please check all PRESENT symptoms relative to this injury:

<b><u>HEAD, FACE &amp; JAW, PAIN / HEADACHE</u></b>	<b><u>NECK:</u></b>	<b><u>MID-BACK:</u></b>	<b><u>NERVES:</u></b>	<b>Doctor's Use Only</b>
<p><input type="checkbox"/> Side <input type="checkbox"/> Front <input type="checkbox"/> Base of Skull <input type="checkbox"/> Top <input type="checkbox"/> Band around Head</p> <p><input type="checkbox"/> Hat-type pressure <input type="checkbox"/> Migraine <input type="checkbox"/> Heavy head <input type="checkbox"/> Throbbing from neck <input type="checkbox"/> Affects Vision <input type="checkbox"/> Produces Nausea <input type="checkbox"/> Incapacitating</p> <p><b><u>FACE:</u></b> <input type="checkbox"/> Pain <input type="checkbox"/> Flushing <input type="checkbox"/> Twitching</p> <p><b><u>JAW:</u></b> <input type="checkbox"/> Pain <input type="checkbox"/> Clicking</p> <p><b><u>WORSE WHEN:</u></b> <input type="checkbox"/> Sleeping <input type="checkbox"/> Eating</p> <p><b><u>EYES, EARS, NOSE, THROAT &amp; MOUTH:</u></b></p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Strain <input type="checkbox"/> Red <input type="checkbox"/> Light hurts <input type="checkbox"/> Double vision <input type="checkbox"/> Spots <input type="checkbox"/> Glasses</p> <p><b><u>EAR:</u></b> <input type="checkbox"/> Ache <input type="checkbox"/> Ringing</p> <p><b><u>NOSE:</u></b> <input type="checkbox"/> Bleeding</p> <p><b><u>THROAT:</u></b> <input type="checkbox"/> Sore <input type="checkbox"/> Painful <input type="checkbox"/> Tightness <input type="checkbox"/> Swallow Problems</p>	<p><input type="checkbox"/> Weakness <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Pain on motion <input type="checkbox"/> Limited motion <input type="checkbox"/> Throat muscles swollen/sore</p> <p><b><u>WORSE:</u></b> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day</p> <p><b><u>SHOULDER:</u></b> <input type="checkbox"/> Local pain <input type="checkbox"/> Pain Down Arm <input type="checkbox"/> Pain on motion</p> <p><input type="checkbox"/> Limited Pain <input type="checkbox"/> Pain from Neck</p> <p><b><u>WORSE:</u></b> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day</p> <p><b><u>ARMS:</u></b> <input type="checkbox"/> Local Pain <input type="checkbox"/> Radiates from Neck <input type="checkbox"/> On movement <input type="checkbox"/> Down arm- Sleeping <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Pins and needles <input type="checkbox"/> Swelling <input type="checkbox"/> Cold Hands <input type="checkbox"/> Cannot Raise <input type="checkbox"/> Loss of Grip Strength <input type="checkbox"/> Down arm end of day</p> <p><b><u>LOSS OF FEELING</u></b></p> <p><input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Fingers</p>	<p><input type="checkbox"/> Weakness <input type="checkbox"/> Pain <input type="checkbox"/> Spasms <input type="checkbox"/> Rib pain</p> <p><b><u>WORSE:</u></b> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day</p> <p><b><u>LOW-BACK:</u></b> <input type="checkbox"/> Weakness <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Pain on motion <input type="checkbox"/> Limited motion</p> <p><b><u>WORSE:</u></b> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day</p> <p><b><u>PAIN IN:</u></b> <input type="checkbox"/> Hip <input type="checkbox"/> Tailbone <input type="checkbox"/> Groin</p> <p><b><u>HIPS, KNEES, LEGS:</u></b> <input type="checkbox"/> Local Pain <input type="checkbox"/> Radiating pain <input type="checkbox"/> From back <input type="checkbox"/> On movement <input type="checkbox"/> Down leg <input type="checkbox"/> Knee-Swelling <input type="checkbox"/> Sciatica <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of Feeling <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Cramps – Spasms</p> <p><input type="checkbox"/> Charlie horses</p> <p><b><u>FEETS:</u></b> <input type="checkbox"/> Swelling <input type="checkbox"/> Pain on walking <input type="checkbox"/> Pain with back <input type="checkbox"/> Cold <input type="checkbox"/> Numbness</p>	<p><input type="checkbox"/> Burning <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Pins and needles <input type="checkbox"/> Tremor <input type="checkbox"/> Nervous tension <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Poor equilibrium</p> <p><input type="checkbox"/> Loss of balance</p> <p><b><u>SLEEP:</u></b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Poor due to pain <input type="checkbox"/> Excessive amount</p> <p><b><u>FATIGUE:</u></b> <input type="checkbox"/> Must rest during day <input type="checkbox"/> Cannot get enough rest</p> <p><b><u>INTERMITTENT:</u></b> <input type="checkbox"/> Tiredness <input type="checkbox"/> Exhaustion <input type="checkbox"/> Fatigue</p> <p><b><u>CONSTANT:</u></b> <input type="checkbox"/> Tiredness <input type="checkbox"/> Fatigue <input type="checkbox"/> Exhaustion</p> <p><b><u>WALKING CAUSES:</u></b> <input type="checkbox"/> Tiredness <input type="checkbox"/> Fatigue <input type="checkbox"/> Exhaustion</p> <p><b><u>OTHER:</u></b> _____ _____ _____ _____</p>	

# Additional Information/Past History

Have you had any previous chiropractic, alternative or medical care for other condition(s)?  Yes  No

If yes, discuss. \_\_\_\_\_

Have you ever suffered from or been diagnosed as having:

Broken or Fractured Bones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gall Bladder issues	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cholesterol Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Disease/disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Bladder Control	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Bowel Control	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing Blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Needing a Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestion Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ruptures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures/Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear/Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye/Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other diagnosed conditions not listed:			

## LIFESTYLE

Do you use Tobacco?  
 Yes  No

Do you use Alcohol?  
 Yes  No

Do you use Caffeine?  
 Yes  No

Do you exercise regularly?  
 Yes  No

On average, how many fruits and vegetables do you consume Daily?  
Fruits:  
Vegetables:

Have you ever been hospitalized?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had any x-rays/MRI/radiographic films taken?  Yes  No If yes, what? \_\_\_\_\_

Have you ever had surgery?  Yes  No If yes, describe \_\_\_\_\_

Are you currently taking any prescription medication or over-the-counter medication?  Yes  No

If yes, what? \_\_\_\_\_

Are you currently taking any vitamin or mineral supplements?  Yes  No

If yes, what? \_\_\_\_\_

Have you ever had or do you have any allergic reactions?  Yes  No If so, describe. \_\_\_\_\_

Do any immediate family members have (or had) a significant illness or disease? (i.e., Cancers, Diabetes, Hypertension, Migraines, High cholesterol, Strokes or other serious health conditions?)  Yes  No

If yes, what? \_\_\_\_\_

Is there anything else? Are there additional complaints or seemingly unrelated conditions, not yet covered, that will be helpful in better understanding your case?

**Initial \_\_\_\_\_** Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known, I will tell the doctor when possible so that it can be added to my record.

### Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit to many, may also provide some level of risk. This level of risk is most often very minimal, yet in a rare number of cases injury has been associated with chiropractic care.

Prior to receiving chiropractic care, a health history and physical examination will be completed. These procedures will be performed to assess your specific condition or concern. These procedures will assist the doctor in determining if chiropractic care is needed, or if any further examinations or studies are needed. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system we cannot promise a cure for any symptom, condition or disease as a result of treatment. In addition, the history will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

***Specific risk possibilities associated with chiropractic care:***

**Soreness-** Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy.

**Soft-Tissue Injury** – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft-tissue injuries.

**Rib Injury** – Manual adjusting to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Physical Therapy Burns** – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

**Stroke** – One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

**Other Problems** – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

I, (print name) \_\_\_\_\_, understand and accept that there are risks associated with chiropractic care and I hereby give my informed consent to the examinations deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. My name and other personal or identifying information will be kept confidential following the rules of HIPPA.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interpreter Signature

\_\_\_\_\_  
Date

# Financial and Attendance Policy

This clinic might utilize techniques, services and protocols that insurance carriers may classify as “experimental/investigational”. **As a result, insurance carriers may deny services it deems as a “non-covered service” or “not medically necessary”. This may decrease the insurance-portion of your bill, while increasing your personal-portion of the billed services provided.** It is ultimately in your best interest to know your insurance policy benefits regarding chiropractic care as it varies greatly from plan to plan.

Services	Billed Fees	At “Time-of-Service” Discount Fee
Initial Exam & Diagnosis	\$63.00-\$250.00	\$125.00** (New or if last visit greater than 36 mo.)
Established Pt Exam & Diagnosis	\$36.00-\$168.00	\$70.00** (If last visit between 12-36 months; or scheduled re-exam requiring report)
Adjustment(s)	\$35.00-\$60.00	\$45 (includes therapies)
Various Therapies	\$25.13 - \$53.00	
Functional Medicine Work-up	Non-covered service	\$250
Functional Lab Test	Non-covered service	Varies \$10.00-\$895.00
X-ray/Imaging	Refer out when necessary	

We will submit insurance claims on your behalf and we will work with your insurance company(ies) to receive payments. Non-covered services, denied bills, or slow payments by an insurance company will be billed directly to you. Any balance over 90 days old may be placed with your collection agency. You are responsible for any fees that are incurred by the collection agency. This includes required co-payments and deductible amounts, and certain limitations. We recommend that you call your insurance company before you visit to verify your benefits.

In certain instances your health insurance may not be responsible for you treatment. Additionally information is required if you intend to utilize one of the following options.

1. Worker’s Compensation & Auto Injuries – It is important that you provide us with the names, addresses and telephone numbers of your employer, the insurance carrier, the date and cause of the injury, and the claim number. We will also required your private health insurance information should your claim be denied or our benefits exhausted.
2. Patients without Insurance – We want to work with you if you do not have health insurance. If you need to set up a payment plan, please let us know in advance. Otherwise, we request payment at the time of service.

Providing your insurance information permits us to work on your behalf to verify your insurance policy(s) so that you are utilizing your maximum insurance benefits. If you choose not to provide this information, we are unable to bill your insurance company, therefore, you will be held personally responsible for payment of your services.

**Attendance Policy**

In the event you are unable to make one of your appointments, please call our office in advance. We will reschedule your appointment as needed. **There may be a \$40 charge for a same-day cancellation or appointment show.** If you, the patient, are more than 15 minutes late for you appointment, it is the doctor’s discretion if there will be time to treat or if you will need to reschedule your appointment.

**I acknowledge that I have read, understand and accept the above policies.**

\_\_\_\_\_  
Patient Signature (Parent/Guardian if under 18 years old)

\_\_\_\_\_  
Date

# NOTICE OF PRIVACY PRACTICES

This Notice Applies to Tierney Chiropractic

[As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)]

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED  
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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## **OUR RESPONSIBILITY UNDER THE FEDERAL PRIVACY STANDARD**

In addition to providing you with your rights, as detailed below, the federal privacy standard requires Tierney Chiropractic to:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative and technical safeguards to protect the information.
- Provide you with the notice as to our legal duties and privacy practices with respect to the individually identifiable health information we collect and maintain about you.
- Abide by the terms of this Notice.
- Mitigate (lessen the harm of) any breach of privacy or confidentiality.  
All Accelerate Performance Clinic staff, interns, contracted individuals who are involved in providing your care are expected to follow the privacy practices as stated in the Notice.

## USE AND DISCLOSURE OF HEALTH INFORMATION

Accelerated Performance will not use or disclose your health information without your authorization, except as described in this Notice or otherwise required by law. We reserve the right to change our practices and to make the new provisions effective for all individual identifiable health information we maintain. Should we change our information practices, you may request a copy of the Notice by calling our office (952) 833-3038. The following are examples of how Tierney Chiropractic will use and disclose your health information for treatment, payment and healthcare operations. These examples are not meant to be inclusive, but describe types of uses and disclosures.

### To Provide Treatment

We will use your health information within our office to provide you with health care treatment, including administrative and clinical office procedures. In addition, we may share your health information with health care personnel providing your treatment.

### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in your office. We may do this with insurance forms filed for you via mail or email.

### Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

### Public Health and National Security

We may be required to disclose to Federal officials health information necessary to complete an investigation related to public health or national security

### For Law Enforcement

As permitted by law, we may disclose your health information to law enforcement officials for certain purposes including under limited circumstances, if you are a victim of a crime or in order to report a crime.

### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment or payment. We will be sure to ask your permission first.

## PATIENT RIGHTS

### Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. We will make every effort to honor reasonable restrictions.

### Confidential communications

You have the right to request that we communicate with you in a certain way. We will make every effort to honor reasonable requests for confidential communications.

### Inspect and Copy Your Health Information

You have the right to read review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know.

### Amend Your Health Information

You have the right to ask us to update or modify your records, if you believe your health information records are incorrect or incomplete. To standardize this process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the record in question was not created by our office, is not part of our records, or if the records are determined to be accurate and complete.

### Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations. Tell us in writing the time period you are interested in. Thank you for limiting your request to no more than six years at a time.

### Request a Paper Copy of this Notice

You have the right to obtain a copy of this notice of privacy practice directly from our office. We are required by law to maintain the privacy of your health information and to provide you this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. Please express any concerns to us in writing within 180 days of when you knew or should have known when that/the act had occurred. Please note that the Privacy law prohibits our office from taking any retaliatory actions against you.

### Right to Revoke Authorization

You have the right to revoke this authorization in writing at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy official at Tierney Chiropractic. The written notice must contain the following:

Patient name, Social Security number, date of birth, and a clear statement of your intent to revoke this authorization, date of request and signature. The revocation is not effective until it is received by the Privacy Official.

### Privacy Contact

Dr. Daniel Tierney (Chief Manager)  
Tierney Chiropractic  
6805 Flying Cloud Drive  
Eden Prairie, MN 55344  
(952) 833-3038

You have the right to refuse to sign this authorization. If you refuse to sign, Tierney Chiropractic will not refuse to provide treatment. This Notice is effective December 31, 2010.

**I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Tierney Chiropractic for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledged, understand the content of the Notice of Privacy Practices and have had all my questions answered to my satisfaction.**

Printed Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Printed Name of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Signature of Privacy Officer \_\_\_\_\_ Date \_\_\_\_\_