PRIVACY PRACTICES ACKNOWLEDGEMENTS

ACKNOWLEDGEMENT FORM

I acknowledge that I have read and understand the Notice of Privacy Practices provided by the office of Dr. William L. Krieger DC.

Name_____ Birthdate_____

Signature_____Date_____

INDIVIDUAL PATIENT AUTHORIZATION

MEDICAL RECORDS INFORMATION RELEASE FORM

I give my authorization to use or disclose my protected health information as the Doctor deems necessary with the exception of the following:

◯ Notify me as necessary ◯ No exceptions

◯ Other _____

Is it ok to cordinate with your Primary Care Physician? _____

Name_____

Address_____State_____Zipcode_____

EMAIL/SMS/TEXT MESSAGING

I state my preference to have the office communicate with me via email or text messaging, regarding various aspects of my healthcare, which may include, but not limited to appointments, billing, test results. I understand that email and standard SMS/text messaging are not confidential methods of communication and may not be secure. I further understand that because of this, there is a risk that these types of communication regarding my care may be intercepted and read by a third party.

Print Name_____Date_____

Signature_____Date_____

PAYMENT ASSIGNATION & SIGNATURE RELEASE FORM

With your permission by signing this form, you will not have to sign each individual insurance form as we can print SIGNATURE ON FILE where a signature is required.

I hearby assign payment directly to the office for professional services rendered and I shall be personally responsible for any unpaid balance to the Doctor.

Signature_____Date_____