Please provide us with any additional medical providers that you are currently seeing to help you with your present condition.

PRIMARY CARE PHYSICIAN

Name_____

Address_____

Phone_____

PHYSICAL THERAPIST or MASSAGE THERAPIST

Name_____

Address_____

Phone_____

If you would like a report sent to one of the above please sign below. I authorize Dr. Pike to provide medical information to the above named provider.

Date:_____Signature_____

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that received a copy of Pike Chiropractic Inc., Notice of Privacy Practices for Protected Health Information.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Rep.