NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

DR. ANDREW G. WHEELOCK

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessment and physician certifications.

I have received Dr. Wheelock's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dr. Wheelock has the right to change his Notice of Privacy Practices, and that I may contact the office at any time to obtain a copy of the current Notice of Privacy Practices.

I understand that I may request in writing that Dr. Wheelock restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Dr. Wheelock is not required to agree with my requested restrictions, but if he does agree then the organization is bound to abide by such restrictions.

I give Dr. Wheelock/Wheelock Chiropractic permission to use the following resources in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as, but not limited to, appointment reminders, insurance items, and laboratory results.

Please check desired box:

[ ] You may [ ] You may not call my home or other alternative location and leave a

message on voice mail or in person. Preferred contact number___________________

[ ] You may [ ] You may not mail to my home or other alternative location.

[ ] You may [ ] You may not correspond with me through Email

Preferred Email____

[ ] You may [ ] You may not use my name when thanking the person who referred me to this office.

I understand that I may revoke this consent at any time, except to the extent that Dr. Wheelock has already taken action on this consent.

________________________	________________________	________________
Patient Signature	Patient Printed Name	Date
________________________	________________________	________________
Parent/Guardian Signature	Parent Guardian Printed Name	Date