If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS Office of Civil Rights
200 Independence Ave, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 04/15/2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide CHICO CHIROPRACTIC CENTER with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (Print) _____

Patient's Signature _____

Date _____

Authorized Facility Signature _____

- **I hereby authorize the release of any Medical information necessary for Chico Chiropractic Center to process medical claims.**

_____ _____
Patient's or authorized person's signature Date

- **I authorize payment of medical benefits to Chico Chiropractic Center/Gary Weddell, D.C. for services rendered at 1140 Mangrove Ave, Ste C, Chico, CA 95926.**

_____ _____
Patient's or authorized person's signature Date

- **I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that Dr. Weddell's office will prepare any necessary reports and forms to assist me in making collection from my insurance and that any amount authorized to be paid directly to Dr. Weddell will be credited to my account on receipt. <u>However, I clearly understand and agree that all co-pays and co-insurance are payable at the time of service</u>. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.**

_____ _____
Insured's or authorized person's signature Date