

**TOTAL HEALTH WELLNESS CENTER**

10224 SW Park Way, Suite A Portland, OR 97225 ph: 503.297.1174 fax: 503.297.2623

Chiropractic • Homeopathic • Acupuncture • Massage Therapy

Kelly Hubbard, D.C.  In Yu, DAOM, LAc  Jeannine Corey, L.M.T.  Fran Rodriguez, L.M.T.

**Authorization & Consent to Examine & Treat**

To Whom It May Concern:

I hereby authorize the Providers of Total Health Wellness Center to administer all Medical examination procedures as deemed necessary. I have reported all health conditions that I am aware of and will inform my Practitioner of any changes in my health.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

**Our Cancellation Policy**

Since your appointment time is important and reserved especially for you, we ask that you please call AS SOON AS POSSIBLE, preferably 24 hours in advance, to make any changes to it. This allows us to offer that time to another patient who needs care.

We reserve the right to charge a Missed Appointment Fee of \$55.00 to those patients who miss their appointment without notifying us, or who repeatedly cancel with less than 24 hours notice.

We value your business and strive to ensure that we are always available to you, as well as the rest of our patients, when you need us.

Thank you,

**I understand and agree to the above:**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Acknowledgement of receipt of Notice of Patient Privacy Practices**

I have received the NOTICE OF PATIENT PRIVACY PRACTICES, which describes how The Providers and Representatives of **Total Health Wellness Center** may use and disclose my protected health care information to carry out treatment, payment of services, health care operations and other purposes that are allowed by law. This notice also describes my patient rights and the requirements of **Total Health Wellness Center** to protect my health information.

**Total Health Wellness Center** reserves the right to change the privacy practices that are described in the NOTICE OF PATIENT PRIVACY PRACTICES. All changes will be posted in the clinic. I understand that I may request a copy of this notice at any time and discuss its content with the Privacy Officer.

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**Signature of Patient or Personal Representative** **Date**

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**Printed Name of Patient or Personal Representative** **Description of Personal Representative's Authority**