Woods Chiropractic

8509 Westfield Blvd.
Indianapolis, In 46240
317-257-3919

Notice of Privacy Practices Receipt

I acknowledge that I was offered and/or provided with the notice of Privacy Practices of the Woods Chiropractic.

Patient Name:_____

Date of Birth:_____

Please list any phone numbers that we may call if needed.

_____

May we leave a message at these numbers if we are unable to directly speak with you?

Yes_____ No_____

I give permission for Woods Chiropractic/Dr. Ron Woods D.C., to obtain radiology reports/films or other medical records that pertain to my condition that I am being treated for by this office.

Patient Signature:_____

Date:_____

Practice Employee Signature:_____