OLSON ACUPUNCTURE GROUP

Patient Health Care Team

Here at Olson Acupuncture Group we like to work collaboratively with your health care practitioners whenever possible. Please indicate by circling yes if you wish to have us communicate with your health care professionals. To deny communication, leave form blank. Please sign your name and date.

Medical doctor(s) including specialists:

Name: _____ Location: _____ Yes

Name: _____ Location: _____ Yes

Name: _____ Location: _____ Yes

Name: _____ Location: _____ Yes

Chiropractor: _____ Location: _____ Yes

Physical Therapist: _____ Location: _____ Yes

Dentist: _____ Location: _____ Yes

Massage Therapist: _____ Location: _____ Yes

Personal Trainer: _____ Location: _____ Yes

Name _____
(Please print)

Signature _____ Date _____

Acknowledging Receipt of Notice on Privacy Policy

I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare service of this office. Following HIPPA guidelines, this practice has attempted to provide each patient with a statement of the Privacy Policy.

Patient Signature _____ **Date** _____