ALTERNATIVE HEALING CHIROPRACTIC CENTER

Dianna Loudenbeck, D.C. Abby Stauss, D.C.
576 Donnelly Ave, Coos Bay, Or 97420
Telephone: 541-266-7543 Fax: 541-269-9408

Patient Name: ____

Initials _____ I give permission for the Alternative Healing Chiropractic Center staff to call, e-mail or text message appointment reminders.

Appointment Reminder Preference: ☐ E-Mail ☐ Text Message ☐ Phone Call

Residence Phone Number __________________

Work Phone Number _____________________

Cell Phone Number ______________________ Cell Phone Carrier ___________________

E-Mail Address ______________________________

If I am unavailable to receive telephone communication, I give permission for the Alternative Healing Chiropractic Center staff to leave the following messages. **Check all that apply.**

Residence Phone	**Work Phone**	**Cell Phone**
☐ Leave call back number only; do not leave a detailed message	☐ Leave call back number only; do not leave a detailed message	☐ Leave call back number only; do not leave a detailed message
☐ OK to leave a detailed message on the answering machine	☐ OK to leave a detailed message on the answering machine	☐ OK to leave a detailed message on the answering machine
☐ OK to leave a detailed message with the following person(s) ___________________	☐ OK to leave a detailed message with the following person(s) ___________________	☐ OK to leave a detailed message with the following person(s) ___________________

Dr. Dianna Loudenbeck and/or Dr. Abby Stauss, **MAY discuss** all aspects of my health care with:

____ ________________
Print Name Relationship

____ ________________
Print Name Relationship

____ ________________
Print Name Relationship

As the patient, you may request that any part of your Private Health Information (PHI) not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your physician.

____ ________________
Patient Signature Date