MILLER WHITMER
FAMILY CHIROPRACTIC

PATIENT'S EDUCATION AND PROTECTION

I understand that as a patient of Miller-Whitmer Family Chiropractic & Wellness Center I, and my medical information, have the right to be protected before, during and after treatment.

_____ I have received and reviewed a copy of my Patient's Rights and Responsibilities.

_____ I have received and reviewed a copy of Patient's Confidentiality and Privacy Practices. I understand that my medical information may be subject to outside review by a third party or business associate of Miller-Whitmer Family Chiropractic & Wellness Center for medical and accreditation purposes only.

_____ I have received written instructions regarding the process for filing a grievance or complaint with the staff, doctors, or quality care I have received.

_____ I have received written instructions regarding the process for contacting staff during and after regular business hours, weekends, and holidays. I understand if it is a medical emergency to immediately DIAL 911.

_____

Patient Name

_____

Patient Signature/Date

_____

Staff or Witness/Date

125 Jeff Davis Ave, Long Beach, MS 39560 (228) 868-8885 Fax (228) 868-4991