Michael C. Kennedy D. C.
3002 North 7th Ave.
Phoenix, Az. 85013

Notice of Our Privacy Practices

We are concerned about protecting the privacy of our patients, and will use our best efforts to safeguard your protected information. This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please read it carefully.

Kennedy Chiropractic/ Southwest Multicare collects information from you as required for your treatment, for our business operations, and as may be pursuant to regulatory requirements. Without it, we cannot provide our services. We collect protected information including but not limited to:

- Health history, including present complaint.
- Personal Information, such as name, address, and Social Security Number.
- Claims and financial information, such as claim or group numbers and insurance benefits.

This information we collect is referred to as "protected information" and is used by our office only to carry out our duties in assisting you with healthcare operations. It is our policy not to disclose any protected information about our patients to anyone, except as necessary in the normal course of treatment, payment or business operations without your valid authorization.

We maintain physical, electronic, and procedural safeguards that comply with the federal and state regulations. If you have any questions regarding this notice, please ask.

Informed Consent to Medical/Chiropractic Treatment

I hereby request and consent to the performance of Physical Medicine and any other medical procedures, including examination, tests, diagnostic x-ray(s), and physical therapy techniques (or the patient named below for which I am legally responsible) which are recommended by the doctor of medicine at this facility and other licensed medical doctors who now or in the future will render treatment to me while employed by, working for or associated with, or serving as a back up for the medical doctor at this facility.

I have had an opportunity to discuss with the office personnel the nature, purpose and risks of recommended procedures, and had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read/or have had read to me the above explanation of the treatment plan. By signing below, I state I have weighed the risks in undergoing treatment, and have myself decided that is in my best interest to undergo the treatment as recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____

Signature of Patient Date