Biotech Natural Medicine, Inc.
Dr. Tim McCullough, DC, DABCI, APC

Houston
1414 S. Friendswood Dr. Ste. 310
Friendswood, TX 77546
Phone: 281-996-7701

Albuquerque
4801 Lang Ave NE UNIT 110,
Albuquerque, NM 87109
Phone: 281-996-7701

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient at this clinic, hereby authorize Dr. McCullough and whomever he may designate as his assistant, to administer examinations and treatment as is necessary, and to perform therapy and adjustments and such additional therapy or procedures as are considered therapeutically necessary during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment. The reasons that the above named treatment are considered necessary, the advantages and possible complications, if any, as well as possible alternative modes of treatment which are explained to me by Dr. McCullough, and I certify that no guarantee or assurance has been made as to the results that may be obtained. I also understand that any supplements that are recommended for me are an aid in supplying the body those nutrients that Dr. McCullough has determined may be of benefit to me.

DATE: _____

SIGNED: _____

WITNESS: _____

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Patient Acknowledgement of Disclosure of Protected Health Information

Patient's Name: _____ Date: _____

I, the undersigned, do agree the above referenced office may contact me regarding any information necessary in the operation of the clinic. This includes, but is not limited to, patient follow-ups, appointments, medical reports and information that the doctor or staff deems necessary in providing healthcare services to you.

In accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security, Section 164.520 (c)(2)(i) and Section 164.520 (c)(2)(ii), I have received written notice of this office's privacy compliance.

My signature on this letter is written acknowledgement of notification of receipt.

_____ _____

Signature of patient (or guardian) Date of signature

*A copy of this notification is given to you (upon request) and the original will be kept in your medical file.

Acknowledgement of this signature is verified and witnessed by:

_____ _____

Privacy Officer Date of signature