Integrated Wellness Solutions
Dr. Muffit Jensen DC, CKTP
2116 N Glenoaks Blvd, Suite A
Burbank, CA 91504

NOTICE OF PRIVACY PRACTICES

The privacy of your medical information, as described in the HIPAA Privacy Act, is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other health care providers to assist them in treating you. We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Name (printed) Signature

_____

Date

NOTICE

State law allows any person to provide nutritional advice or give advice concerning proper nutrition – which is the giving of advice as to the role of food and food ingredient, including dietary supplements. This state law does NOT confer authority to practice medicine or to undertake the diagnosis, prevention, treatment, or cure of any disease, pain, deformity, injury, or physical or mental condition and specifically does not authorize any person other than one who is a licensed health practitioner to state that any product might cure any disease, disorder, or condition.

_____ _____

Name (printed) Signature

_____

Date

INFORMED CONSENT

I am solely responsible for the decision to see Dr. Muffit Jensen DC, CKTP for Chiropractic Therapy. I recognize that some recommendations may not prove to be successful. I understand some recommendations may be novel. I agree to participate in an active manner, monitor my progress, and report any concerns to Dr. Muffit Jensen or her staff. I also understand that any significant symptoms should be reported to my doctor. It is also recommended that I discuss the use of any nutritional supplements with my doctor before implementing.

_____ _____

Name (printed) Signature

_____

Date