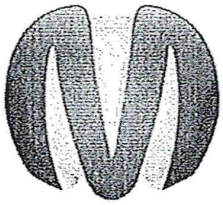

MEANS FAMILY CHIROPRACTIC

Mark C. Means, D.C., P.A.
Rick A. Means, D.C., P.A.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for practice reminders, birthday greetings or promotions by:

_____ Mail

_____ Email --- at email address _____

_____ Telephone --- at phone number(s) _____

_____ Voice Mail

_____ Text Message

_____ I authorize the doctor to personally discuss with me products that may benefit my health or condition.

List below the names and relationship of people to whom you authorize the Practice to release Personal Health Information.

_____ _____

_____ _____

_____ _____

_____ _____

Print Name **Date**

_____

Signature