

Amon Chiropractic & Wellness Center

Dr. Sheila Amon

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I have received, read and understand my Notice of Privacy Practices at Dr. Sheila Amon, Amon Chiropractic & Wellness Center and/or Your Spine, L.L.C.

Signature

Date

I _____ give the staff of Dr. Sheila Amon, Amon Chiropractic & Wellness Center and/or YourSpine, L.L.C. authorization to communicate information on my behalf to _____ in the following areas:

- _____ Appointments
- _____ Account Balance/Billing Information
- _____ Insurance Company needs
- _____ Health Issues

I also give authorization to the staff of Dr. Sheila Amon, Amon Chiropractic & Wellness Center and/or YourSpine, L.L.C. to:

- _____ Leave a message on answering machine at home/work
- _____ Leave a message on cell phone(s)
- _____ Communicate via e-mail

Patient Signature

Date

Witness

Date