

**WARWICK VALLEY CHIROPRACTORS**  
214 Ronald Reagan Blvd.  
Warwick, NY 10990

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## **PRIVACY POLICY**

In our efforts to insure your privacy as a patient in our office, we would like you to read this attached privacy notice, and then sign below stating that you have done so. Please also read the following request for authorization for various information uses in our office and then sign if this is agreeable to you.

It is our desire for our staff to use your name, mailing address, telephone number, and/or email address for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues, as well as to advise you about health-related meetings, workshops and products. Specifically, our staff would like to leave email, telephone, and/or text messages regarding your appointments on voicemail systems, or to provide such information to the person(s) who answers the phone, using the contact information provided.

In addition, in the case that your insurance company is billed, your personal and health information may need to be shared with the insurance company to determine your eligibility for compensation.

The use of this information is intended to make your experience with our office more productive, and to further enhance your access to quality healthcare.

**Your signature below indicates your authorization of these activities.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.*

**Please also sign below to confirm you have read the privacy notice.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date