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Certification and Assignment Form
Dr. Nicole Sletten, D.C. and/or Dr. Bret Buffalohead, D.C.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to Dr. Nicole Sletten and/ or Dr. Bret Buffalohead all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Nicole Sletten and/or Dr. Bret Buffalohead may use my health care information and may disclose such information to the above –Named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable to related services.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, understand and have been provided with a ***Notice of Information Practices*** a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

• The right to review the notice prior to signing this consent,
• The right to object to the use of “my health information” for directory purposes, and
• The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____ _____

Print name of Patient, Parent, Guardian or Personal; Representative Relationship to Patient