ACKNOWLEDGMENT OF RECEIPT
OF
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.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS AND MAY REPLACED AS NECESSARY DUE TO CHANGES IN HIPPA REGULATIONS.

Please list below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

I hereby authorize Advanced Chiropractic Associates, PLLC to contact me regarding appointment reminders and any other information related to my treatment and care via the following: *Please provide a valid phone number or email address for all that apply.*

Telephone:_____ **(Messages may/may not be left at this number)**

Telephone:_____ **(Messages may/may not be left at this number)**

Email:_____

Text message:_____