ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,____,{patient's name} acknowledge that I have read, reviewed, understand and agree to the Notice of Privacy Practices of Community Chiropractic, which describes the Practices's policies and procedures regarding the use or disclosure of my Protected Health Information created, received or maintained by the practice.

_______________ DATE

_________________________________ PATIENT'S SIGNATURE

_________________________________ PRINT NAME

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The practice has made a good-faith effort to obtain an acknowledgement of ___________________________________{patient's name} receipt of our Notice of Privacy Practices. In spite of these efforts, the practice has been unable to obtain a signed acknowledge of receipt for the following reasons (check all that apply)

Patient Unavailable
Patient Physically Unable
Patient Unwilling

In an effort to obtain the patients acknowledge, the Practice has attempted to provide patient with a notice of Privacy Practice
in the following manner (check all that apply)

Personally______________Mail__________________Phone follow up_________
Other____

___________________ DATE

___________________________________ SIGNATURE

__________________________________ PRINT NAME OF PHYSICIAN

COMMUNITY CHIROPRACTIC
NAME OF PRACTICE