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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND

COMMUNICATION PREFERENCES AND AUTHORIZATION

Please read and initial:

______I acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPAA). I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices (HIPAA). I understand that this form will be placed in my patient chart and maintained for six (6) years unless I provide written notice to revoke this authorization.

_____ I understand that the staff at Anderson Chiropractic Center may on occasion send me notifications or newsletters via mail or e-mail. I authorize this type of communication to the address and or e-mail address I have provided on my initial paper work.

_____ I understand that Anderson Chiropractic Center utilizes phone calls, text messaging and e-mail messaging for appointment reminders and or missed appointments. I authorize the staff at Anderson Chiropractic Center to contact me with these reminders and leave a voice mail message if necessary.

____ ____/____/_____

Patient Name Printed Date

____

Patient Signature

____

Parent/ Guardian Name & Relationship Printed (If under 18)

____

Parent or Guardian Signature (If under 18)