PREMIER CHIROPRACTIC + PERFORMANCE

HIPAA Omnibus Rule

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Print Patient Name: _____

I acknowledge that I have been provided a copy of currently effective Notice of Privacy. A copy of this signed, dated document shall be as effective as the original.

Date: _____

_____
Signature of Patient or Personal Representative

_____
Signature of Witness / Office Representative

You may refuse to sign the acknowledgement & authorization. In refusing, this practice will not be allowed to process your insurance claims.

I acknowledge that I declined the Notice of Privacy Practices provided:
Date: _____

_____
Signature of Patient or Personal Representative

_____
Signature of Witness / Office Representative

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Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign
___ Communication barrier ___ Emergency situation occurred with patient Other: (explain):
_____
___

_____
Signature of Office Representative