CUSTOM CHIROPRACTIC
PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

If you are a minor, or if you are being represented by another party:

_____ _____
Personal Rep (Print) Personal Rep (Signature)

_____ _____
Description of the authority to act on behalf of the patient Date

The patient named below has chosen not to sign the Privacy Practices Acknowledgement. This does not affect the type of treatment or quality of care the patient will receive in our office. We have attempted, to the best of our ability, to provide this patient with a copy of our Notice of Privacy Practices.

_____ _____
Name of Patient (Print) Date

_____ _____
Office Employee Title