CHIROPRACTIC SOLUTIONS by dr julie

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish, at which time the doctor may choose not to accept your case.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

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Please print your name here

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Signature

Date:____________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- **The patient refused to sign.**
- **Due to an emergency situation it was not possible to obtain an acknowledgment**
- **We weren't able to communicate with the patient**
- **Other (Please provide specific details)**

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Employee signature__________________________________

Date____________