**Stramara Chiropractic, S.C.**

501 Hall Street Watertown, WI 53094

(920) 261-5784

Acknowledgement of Receipt of

Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq. and regulations there under, as amended from time to time (collectively referred to as “HIPAA”). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that our office, Stramara Chiropractic, S.C. or its Business Associates may use or disclose your Protective Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for Stramara Chiropractic’s S.C.’s healthcare operations purpose.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand our office’s Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While our office has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the office where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of our office, which describes Stramara Chiropractic S.C.’s policies and procedures regarding the use and disclosure of any of your Personal Health Information, created, received, or maintained by Stramara Chiropractic, S.C..

Please note: Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

Patient Name: Date of Birth:

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Stramara Chiropractic, S.C..

I understand that the Notice describes the uses and disclosures of my protected health information by Stramara Chiropractic, S.C. and informs me of my rights with respect to my protected health information.

I understand Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

Patient’s Signature or that of Legal Representative Printed Name of Patient or that of Legal Representative

Today’s Date If Legal Representative, Indicate Relationship

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 acknowledgement

Communications barriers prohibited o

obtaining the acknowledgement

Other (please specify)

:

Employee Name Today’s Date