

CHIROPRACTIC | ACUPUNCTURE | NUTRITION

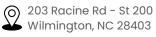
Wilmington NC

✓ HIPPA Signature Form

Simple Well Being, LLC

203 Racine Dr, Suite 200 • Wilmington, NC 28403 Phone: (910) 994-2344 • www.SimpleWell-Being.com

Patient Name:
Date of Birth:
Phone Number:
At Simple Well Being, LLC, we are committed to protecting your health information. The Health Insurance Portability and Accountability Act (HIPAA) requires us to provide you with a Notice of Privacy Practices that outlines how we may use and disclose your protected health information (PHI) and how
you can access this information.
Please review the following:
I have received or been offered a copy of the Simple Well Being, LLC Notice of Privacy Practices.
 I understand that I have the right to request restrictions on how my health information is used or disclosed, though the practice is not required to agree to those requests.
• I understand that I may revoke this consent in writing, except to the extent that the practice has already made disclosures in reliance on my prior consent.
 I understand that Simple Well Being, LLC may use or disclose my health information to carry out treatment, payment, or healthcare operations.
Patient Acknowledgement & Signature:
□ I acknowledge receipt of the Notice of Privacy Practices.
□ I was offered a copy but declined.
$\hfill \ensuremath{I}$ I have had the opportunity to ask questions and understand the information provided.
Patient Signature:
Date:
If signed by a personal representative (e.g., parent, guardian, power of attorney):
Name of Representative:
Relationship to Patient:
Signature of Representative:
Date:
Office Use Only
If patient/personal representative refuses to sign this acknowledgment:
□ Patient/representative refused to sign despite being given a copy of the Notice of Privacy Practices. Staff Initials: Date:





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