Active Care Chiropractic

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the **Health Insurance Portability & Accountability Act of 1996 ("HIPPA"),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers-this includes, but is not limited to my attorney and/ or insurance company
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:___________________________________

Relationship to Patient:___________________________

Patient Signature: _______________________________

Date: ____