HIPPA Acknowledgement Form

Patient Name ________________________________

Relationship to Patient ________________________________

Name if not Patient ________________________________

I understand that, under the Health Insurance Portability and 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 care among the Providers who may be involved in that treatment directly or indirectly.

*Obtain payment from designated third-party payers.

*Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my Health Information (available at the following link HIPPA Notice of Privacy Practices or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Elliott Chiropractic has the right to change its Notice of Privacy Practices from time to time and that I may contact Elliott Chiropractic at any time to obtain a current copy of the Notices of Privacy Practices.

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

I understand that I may revoke this consent in writing at any time, except to the extent that Elliott Chiropractic has acted relying on this consent.

By Checking the box, I acknowledge that I received and read the organization Notice of Privacy Practices.

Patient Signature ________________________________