Acknowledgement of Receipt of Notice of Privacy Practices

Action Chiropractic, LLC

Name of Patient: _____

I hereby acknowledge that I received a copy of Action Chiropractic's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I give permission for my medical condition, all medical records and/or billing to be discussed with the following person(s):

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

My instructions expire on: _____OR expire automatically one year from signature date

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient: _____

.