# FALL CREK CHIROPRACTIC

## PATIENT ACKNOWLEGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the uses and limitation of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

For use and/or disclosure of Protected Health Information (PHI) in order to carry out treatment, payment, and healthcare operations at Fall Creek Chiropractic (FCC).

I hereby state that by signing this Consent I acknowledge and agree as follows:

1. The Practice's (FCC's) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of uses and/or disclosures of my Protected Health Information (PHI) which are necessary for FCC to provide treatment to me, to obtain payment for that treatment, and to carry out its health care operations. FCC explained to me that the Privacy Notice would be available to me in the future at my request. FCC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to signing this Consent.

2. FCC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. FCC's Notice of Privacy Practices can be provided if asked for at the front desk. I may also request a copy from this office at any time to be sent by US Mail.

4. This Notice of Privacy Practices includes a description of my rights and the duties of FCC with respect to my protected health information.

I have read and understand the above notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. I acknowledge that I have received a copy of Fall Creek Chiropractic's Notice of Privacy Practices for Protected Health Information.

Name (printed) : _____

Signature: _____ Date: _____