JORGENSEN
Family Chiropractic

HIPPA COMPLIANCE PATIENT CONSENT FORM

Notice of Privacy Policies

Patient Name: _____ Birthdate: _____

I have received and understand this practice's Notice of Privacy Practices .The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

You may decline to sign this acknowledgement. In declining, we ***MAY NOT BE ALLOWED*** to process your insurance claims.

May we confirm appointments via phone, text or email? Y / N

May we leave a message on your answering machine or voicemail of the number you provided? Y / N

May we communicate with you about your private health care information via email, encrypted or unencrypted? Y / N

May we release or communicate your private health care information with another person(s)? Y / N

If yes, please name them and their relationship to you:

_____

_____

_____

By signing, I acknowledge the receipt of this practice's Privacy Policies and consent to their terms:

Signature: _____ Date: _____

Relation to patient (if signed by a representative): _____

OFFICE USE ONLY: I attempted to obtain the patient's signature (or representative) on this consent form but was unable to because:

_____ It was an emergency treatment.

_____ The patient declined to sign.

_____I could not communicate with patient.

_____ Other: _____

Signature of Office Witness _____ Date: _____