

PINHOOK CHIROPRACTIC CLINIC
100 LA RUE FRANCE
LAFAYETTE, LA 70508

PATIENT ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 insurance and third party payers.
- Conduct normal healthcare operations such as quality assessment 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 organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization 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 that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

I understand that you may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

Patient Name: _____

Patient Date of Birth: _____

Signature: _____

Relationship to patient (ONLY if patient is a minor): _____

Today's Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date | Initials | Reason |
|------|----------|--------|
| | | |