HIPPA Privacy Rule Receipt of Notice of Privacy Practices
At Back Care Specialists
Written Acknowledgement Form

I, _____, have received a copy of the Notice of Privacy Practices at Back Care Specialists.

I understand that this notice is effective as of 6/1/2005. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____

_____

Dr. Cady Date
Privacy Official

Patient Authorization for appointment reminders and scheduling related matters

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from **Back Care Specialists**, or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (Printed) _____ Signature _____ Date _____

Patient Authorization for contact regarding chiropractic care, related health services, and/or related health products

It is our desire for our staff to use your name, address, and/or telephone number for purpose of contacting you to advise you about health related meetings, workshops, and products.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality health care.

If you choose not to authorize this information, your decision will have no adverse effect on your care from **Back Care Specialists**, or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (Printed) _____ Signature _____ Date _____

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.