Equ.S.T. CHIROPRACTIC

Name: _____

DOB: _____

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

PATIENT NAME or LEGAL GUARDIAN (PRINT) DATE

_____

SIGNATURE

Communication Preferences

I, _____ hereby consent and state my preference to have my chiropractor, Dr Bonnie Harder and/or Equ.S.T. Chiropractic, PLLC staff communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders and my private health information at the following (**please check the ones you agree to**):

[ ] CALL [ ] TEXT [ ] EMAIL

OFFICE USE ONLY

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date _____ Attempt _____

Doctor/Staff Name _____

Updated 07/18/2023