Fully Known Chiropractic

714 State Hwy 248 Suite 503 Branson, MO 65616 417-213-0897

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices. I also understand that Fully Known Chiropractic has the right to change its Notice of Privacy Practices and that I may contact the clinic at any time to obtain a current copy of the Notice of Privacy Practices. I also understand that I may withdraw my consent in writing.

I give my doctor and/or other Fully Known Chiropractic/Providence Aesthetics and Wellness Center personnel and collaborative team members to contact me in the following ways: (Please mark and fill out the permitted ways to contact you. If unavailable, please indicate if we can leave a message)

* Text (number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone (number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message YES or NO
* Work (number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message YES or NO
* Other (number)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message YES or NO
* Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name or Legal Guardian (PRINT) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature Date

**OFFICE USE ONLY**

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| We have made the following attempt to obtain the patient’s signature acknowledging receipt of the Notice of Privacy Practices:Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attempt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |