Infinity Chiropractic and Wellness

HIPAA Acknowledgment of Receipt of Privacy Practices

By signing this form, you acknowledge that you have received a copy of Infinity Chiropractic and Wellness's Notice of Privacy Practices. This notice explains how your health information may be used and disclosed, and your rights with regard to your health information under the Health Insurance Portability and Accountability Act (HIPAA).

You are not required to sign this form to receive care, but we are required to document that we made a good faith effort to provide you with this notice.

Patient Name (Printed): _____

Signature: _____

Date: _____

If the patient is a minor or has a personal representative:

Representative Name (Printed): _____

Relationship to Patient: _____

Signature of Representative: _____

Date: _____

For Office Use Only:

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

☐ Patient declined to sign

☐ Communication barriers prevented acknowledgment

☐ Emergency situation prevented acknowledgment

☐ Other (please specify): _____