**Dotson Chiropractic**

720 S Glenwood Ave, Suite 100

Dalton, GA 30721

**Notice of Privacy Practices Acknowledgment**

 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 including any additional healthcare

 providers who may be involved in that treatment.

* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments.

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 Dotson Chiropractic 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 operation. I also understand that a decision regarding any request will be made in a reasonable time.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Office Use Only**

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

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Initials:\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_