Acknowledgement of Receipt of Notice of Privacy Practices

Patient Information:

Name: _____

Address: _____

Telephone: _____

Acknowledgement of Receipt of Privacy Practices:

I, _____, acknowledge that I have been provided and received a Notice of Privacy Practices from Long Chiropractic Center.

Signature: _____ Date: _____

If this acknowledgement is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____