GRANTS PASS CHIROPRACTIC CLINIC

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** _______________________

I hereby acknowledge that I have viewed a copy of GRANTS PASS CHIROPRACTIC CLINIC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices on the following date,

_____________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgment at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgment (Explain)

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- ☐ Other (Specify)

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