Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information

I understand I have a right to review this office's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Krauseneck Chiropractic, PLC. The Notice of Privacy Practices is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Krauseneck Chiropractic, PLC's duties with respect to my protected health information. I acknowledge that Notice of Privacy Practices has been provided to me. *

Krauseneck Chiropractic, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Be advised that common areas of this office (entrance, lobby, hallway) may be under recorded surveillance for the sole purpose of safety, security, and quality improvement however, videos are not used as part of treatment or medical documentation. The undersigned does hereby acknowledge that this office uses text messaging and email for general office communication and appointment reminders through our software company as well as phone calls for direct communication with the office. Please check which means you would prefer for your reminders:

_____Email _____Text

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

*A copy of the Notice of Privacy Practices is available at the front desk. We will be happy to provide a copy for you to take home if you so desire.