

SUMMIT CHIROPRACTIC & REHABILITATION, P.C.
114 Village Place, Suite #302
Dillon, Co 80435
(970) 513-9234

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the Notice of Privacy Practices and have been given from Summit Chiropractic and Rehabilitation, P.C. and have been given opportunity to received a printed copy to take with me if I choose to do so.

X _____
Printed Name of Patient

Date of Birth

X _____
Signature of Patient or Representative

Date

Permission and Access Ability to Patient's Information

Does Summit Chiropractic and Rehabilitation, P.C. staff have permission to leave detailed messages at your home number regarding any tests that you may incur here as a patient? (For example blood tests, MRI's, Cat Scans, X-rays?) (Please circle) YES NO

I hereby allow employees of Summit Chiropractic and Rehabilitation, P.C. to divulge any information regarding blood tests, MRI's, Cat Scans, X-rays to the following individuals:

(Name)

(Relationship to Patient)

(Name)

(Relationship to Patient)

FOR OFFICE USE ONLY

Documentation of Good Faith Efforts
To obtain patient's acknowledgement that they received provider's
Notice of Privacy Practices

The above named patient presented to the office on _____, and was provided with a copy of the Summit Chiropractic and Rehabilitation's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtain because:

- Patient refused to sign.
- Patient was unable to sign or initial because: _____.

Signature of Employee

Date