PRE-NATAL NEW PATIENT FORMS

Please print clearly

GENERAL INFORMATION (please complete in detail, all information is confidential)

Patient Last Name: _____ First Name: _____ MI: ___

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____

Email: _____

Phone (Work): _____ Phone (Cell): _____

Number of Children: ____

Names & Ages: _____

_____

_____

Spouse Name: _____

Phone: _____

Today's Date	Age	Date of Birth	Social Security Number	❑Married	❑ Single
/ /		/ /	- -	❑Divorced	❑Widowed

In Care of: _____ Relation: _____Phone: _____

(Parent or financially responsible person)

Patient Employer's Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Occupation: _____

Driver's Lic. #:

EMPLOYED

❑ Full Time ❑ Part Time

❑ Retired ❑ Not Employed

STUDENT

❑ Full Time ❑ Part Time

Referred By:_____

If you were not referred to us, how did you hear about Alpine Wellness Chiropractic? _____

_____

INSURANCE INFORMATION

❑Check If Self-Pay

Primary Insurance Company Name

_____

Type: _____ Group: _____Private: _____

Membership/Cert #: _____

Policy / Group #: _____

Complete ONLY if patient is not the insured

Insured's Name: _____

M F ❑ Married ❑Single ❑Widowed ❑Divorced

Patient's Relationship to Insured: _____

Insured's Date of Birth: _____

Insured's Employer: _____

Secondary Insurance Company Name

_____

Type: _____ Group: _____Private: _____

Membership/Cert #: _____

Policy / Group #: _____

Complete ONLY if patient is not the insured

Insured's Name: _____

M F ❑ Married ❑Single ❑Widowed ❑Divorced

Patient's Relationship to Insured: _____

Insured's Date of Birth: _____

Insured's Employer: _____

PRE-NATAL NEW PATIENT FORMS
Please print clearly

Mom's Name: _____ Baby's Dad's Name: _____

Have you ever seen a chiropractor before? ❑Yes ❑No

When? _____ How many times? _____

For what reason? _____

D.C. Name(s): _____

The reason for this visit is: ❑Well-Mama Pre-Natal Chiropractic Care ❑Baby Breech Presentation

❑Headache ❑Backache of Pregnancy ❑Trauma ❑Chronic Condition ❑Other:_____

Pregnancy History (so far)

How many babies are you having? ❑Single ❑Twins ❑Multiples: _____

Week of gestation: _____ Due Date: _____ Sex of Baby (if known): ❑Female ❑Male

Where are you planning to deliver? ❑ Hospital Birth Center ❑ Independent Birth Center ❑ Home

Type of Birth: ❑Vaginal ❑VBAC ❑Planned Cesarean Section

Are you planning to Vaccinate? ❑NO ❑YES Would you like vaccination information? ❑NO ❑YES

Are you planning to Breastfeed? ❑NO ❑YES Would you like breastfeeding information? ❑NO ❑YES

How many exposures to ultrasound so far? _____

Are you getting 8 hours of sleep per night? ❑NO ❑YES

Are you eating 60-80g of protein per day? ❑NO ❑YES

Are you having any food cravings?

❑NO ❑YES List food and frequency: _____

Are you drinking ½ of your body weight in ounces of water per day? ❑NO ❑YES

Are you drinking coffee or caffeinated beverages?

❑NO ❑YES ❑1 ❑2 ❑3 ❑4 drinks/❑day/ week/❑month

Are you exercising regularly?

❑NO ❑YES List activity and frequency: _____

What Vitamins/Supplements are you taking?

❑Prenatal Vitamins ❑Fish Oil ❑Vitamin D_3 ❑Other:_____

Are you taking any prescription medications?

❑NO ❑YES List drug and reason: _____

Have you used any over-the-counter medications?

❑NO ❑YES List drug and reason: _____

Are you using tobacco products?

❑NO ❑YES ❑1 ❑2 ❑3 ❑4 packs/day

Are you drinking alcohol?

❑NO ❑YES ❑1 ❑2 ❑3 ❑4 drinks/❑day/ week/❑month

Are you using Recreational drugs?

❑NO ❑YES ❑Marijuana ❑Other: _____

❑Daily ❑____x/week ❑____x/month

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

Pregnancy History (continued)

	During Pregnancy	Also Before Pregnancy	Describe (include Dates where applicable)
Notable Falls/Injuries?	❑	❑	
Motor Vehicle Accidents (MVA)?	❑	❑	
Near-miss MVA?	❑	❑	
Headaches?	❑	❑	
Neck Pain?	❑	❑	
Allergies, Sinus Problems?	❑	❑	
Dizziness?	❑	❑	
Seizures?	❑	❑	
Thyroid problems?	❑	❑	
Upper Back pain?	❑	❑	
Anemia?	❑	❑	
High Blood Pressure?	❑	❑	
Heart Problems?	❑	❑	
Asthma?	❑	❑	
Diabetes?	❑	❑	
Morning sickness?	❑	❑	
Heartburn/Indigestion?	❑	❑	
Low Back Pain?	❑	❑	
Abnormal bleeding?	❑	❑	
Swollen ankles?	❑	❑	
Were you hospitalized?	❑	❑	
Any other Illnesses?	❑	❑	

Past History

Please tell us if you have had any of the following:

- ❑ Fractured bones
  List:_____
  _____
- ❑ Surgeries
  List:_____
  _____
  _____
- ❑ Arthritis
- ❑ Convulsions, Epilepsy
- ❑ Skin Problems
- ❑ Cancer
- ❑ Stroke
- ❑ Frequent Colds, Flu
- ❑ Depressed
- ❑ Irritable
- ❑ Under Stress
- ❑ Eating Disorders
- ❑ Trouble Sleeping
- ❑ Trouble Concentrating
- ❑ Learning Disability
- ❑ ADD / ADHD
- ❑ Mood Changes
- ❑ Pain with Cough or Sneeze
- ❑ Ear Infections
- ❑ Ringing in Ears ❑R ❑ L
- ❑ Hearing Loss ❑R ❑ L
- ❑ Blurred or Double Vision
- ❑ Jaw Pain or Clicking (TMJ)
- ❑ Numbness, Tingling, Pain in Arms, Hands, Fingers
- ❑ Shoulder Pain ❑R ❑ L
- ❑ Chest Pain
- ❑ Digestive Problems
- ❑ Ulcers
- ❑ Gall Bladder Problems
- ❑ Liver Problems
- ❑ Kidney Trouble
- ❑ Bedwetting
- ❑ Numbness, Tingling, Pain in Buttocks, Legs, Feet, Toes
- ❑ Hip Pain ❑R ❑ L
- ❑ Foot Trouble ❑R ❑ L
- ❑ Difficulty in Excessive Standing, Sitting, Riding, Bending, Lifting, Twisting: _____
- ❑ Varicose Veins
- ❑ Hemorrhoids
- ❑ Menstrual Problems (PMS)
- ❑ Fertility Problems
- ❑ AIDS, HIV
- ❑ Former Smoker Quit:_____

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

Pregnancy and Birth History of Other Children (print additional copies as needed)

Child Name: _____ Child Sex: ❑F ❑M Child Birthdate: _____

❑Twins or Multiples:

Child Name: _____ Child Sex: ❑F ❑M

Child Name: _____ Child Sex: ❑F ❑M

Child Name: _____ Child Sex: ❑F ❑M

Name of Obstetrician / Midwife: _____

PREGNANCY

Complications during pregnancy?

❑NO ❑YES List: _____

Ultrasounds during pregnancy? ❑NO ❑YES Number: _____

Vitamins/Supplements during pregnancy:

❑Prenatal Vitamins ❑Fish Oil ❑Vitamin D_3 ❑Other:_____

Prescribed Medications during pregnancy?

❑NO ❑YES List: _____

Cigarette use during pregnancy?

❑NO ❑YES: ❑1 ❑2 ❑3 ❑4 packs/day

Alcohol use during pregnancy?

❑NO ❑YES: ❑1 ❑2 ❑3 ❑4 drinks/❑day/ week/❑month

Recreational drug use during pregnancy?

❑NO ❑YES: ❑Marijuana ❑Other: _____

❑Daily ❑____x/week ❑____x/month

BIRTH/DELIVERY

Did you carry to full term?

❑YES ❑NO How many weeks? _____

Approximately how long did labor last? _____

Location of Birth:

❑ Hospital ❑ Birthing Center ❑ Home

Type of Birth:

❑Vaginal ❑Planned Cesarean Section ❑Emergency Cesarean

Was there Fetal Distress?

❑NO ❑YES Explain: _____

Birth intervention:

❑Anesthesia Administered (Epidural) ❑Induced ❑ Forceps ❑ Vacuum Extraction

Baby presentation at time of delivery?

❑Breech ❑Head first ❑Face first ❑Other:_____

Complications during delivery?

❑NO ❑YES List: _____

Genetic Disorders or disabilities?

❑NO ❑YES List: _____

First Name: _____ Birth Weight: _____lbs. _____oz. Birth Length: _____ inches

First Name: _____ Birth Weight: _____lbs. _____oz. Birth Length: _____ inches

First Name: _____ Birth Weight: _____lbs. _____oz. Birth Length: _____ inches

First Name: _____ Birth Weight: _____lbs. _____oz. Birth Length: _____ inches

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

Complete ONLY of you are experiencing Pain

On a Scale from 1 to 10, identify your current level and type of pain.

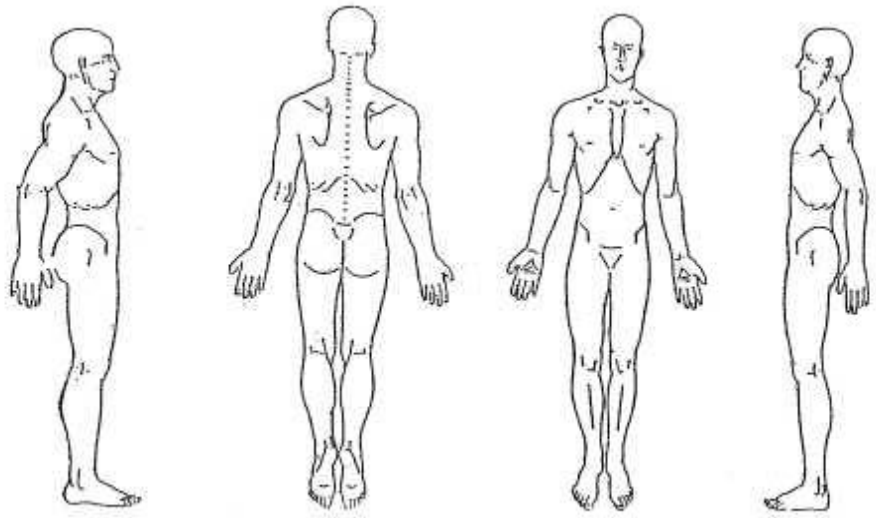
Low…moderate…intense…emergency
1 2 3 4 5 6 7 8 9 10

A = Ache
P = Pins & Needles

B=Burning
S = Stabbing

N=Numbness
O = Other

Please Circle the Specific Area & Note Pain Level and Type



1. Which pain or condition identified is the ***worst***? _____

2. How ***long*** has it bothered you? _____

3. Please describe what makes your condition or symptoms ***worse*** _____
_____

4. Please describe what makes your condition or symptoms ***better*** _____
_____

PLEASE CHECK ONE:

5. Spinal problems can cause painful symptoms. Is your pain ***sharp*** ❑ or ***dull*** ❑?

6. Spinal problems can cause symptoms that may be ***constant*** ❑or ***occasional*** ❑.

7. Are your symptoms worse in the ***A.M.*** ❑or ***P.M.***❑?

8. Do your pains/symptoms ***radiate/travel*** into an extremity or ***stay in one area***? Describe:

_____

_____

_____

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

Additional Information

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us resolve your health concerns: _____

Do your children or spouse have any health problems that you are aware of? _____
_____

Is there any other information you would like us to know?_____
_____
_____
_____
_____

I attest that all the information provided on this form is true to the best of my knowledge.

_____
Signature Date

As part of Dr. Pozner's commitment to improving patient care for prenatal and pediatric patients we are part of the International Pediatric Chiropractic Association's Practice Based Research Network. With patient permission, we collect and submit clinical information related to prenatal and pediatric care provided in our office for the purpose of advancing chiropractic research in these areas. Your personal information is never shared and you will not be contacted by anyone who is not affiliated with Alpine Wellness Clinic, PC.

I give permission for patient info and photos to be used *anonymously* for Research purposes.

_____
Signature Date

Thank You!

T: 303.431.8588 ♦ F: 303.421.9232

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

It is important that each patient understand both the objectives and the methods of chiropractic care.

This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of Vertebral Subluxation. Our chiropractic method of correction is by specific adjustment of the spine and the use of stretching and exercising to maximize the improvement.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of both muscle and nerve function, and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to function properly.

We do not offer to diagnose or treat any diseases or condition other than Vertebral Subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I _____have read and fully understand the above statements.
(Print name)

I, therefore, accept chiropractic care on this basis.

_____

Signature Date

T: 303.431.8588 ♦ F: 303.421.9232

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

FEE STRUCTURE

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$ 65.00
Adjustment	$ 50.00
TOTAL	**$ 115.00**

Please note that if you have been involved in a motor vehicle accident or have health insurance, our fee structure may differ.

Please also note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results, is complimentary.

FINANCIAL POLICIES

1. All first visit charges are payable when services are rendered, if your visit is promotional or you have a gift certificate, please inform the chiropractic assistant.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Films may be release upon request, but must be returned within 30 days. Please allow 24 hours to prepare x-rays for pickup.

3. Payment is required at the time of service. You are responsible for giving your payment when you check in. The front desk staff may ask for your co-payment however, even if someone does not ask, you are responsible for knowing the amount and for payment before your visit.

4. Self-pay patients without insurance are expected to make payment in full on the day services are rendered. If you are unable to pay in full, a "good faith" pre-payment of $25.00 is required and you will need to setup a payment plan and make regularly scheduled payments.

5. Patients are responsible for ALL charges that are not covered by insurance plans. This includes co-payments, deductibles, co-insurance, and non-covered services.

6. ***Insurance companies do not pay for corrective or maintenance care***. Insurance may only be used until maximum therapeutic benefit is achieved, according to insurance company guidelines, usually within the first two weeks of care or a maximum of 12 visits. If during the course of corrective or maintenance care you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered corrective or maintenance and may be covered by your health plan. Please alert the front desk staff of any significant changes in your condition status as soon as possible so that your insurance can be billed accordingly.

7. If you have a service that is ***not a covered benefit*** of your insurance, such as weight loss or nutrition counseling, you will be financially responsible for payment of such services. We will not change reasons for visits. All claims will be filed in accordance with the documentation in the chart.

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

FINANCIAL POLICIES (continued)

8. When you receive a bill from us, payment is expected within 30 days. If you need to make payment arrangements, please contact front desk staff before the 30 day period. Failure to pay will result in the account being assigned to a collection agency.

9. There will be a $25 fee for all returned checks..

10. If payments are not received in accordance with the above guidelines, the accounts will be turned over to the collection agency, Rickenbaker Group. The patient will be responsible for any collection fees, attorney fees and other costs involved in referring their delinquent account to the collection agency.

11. All lab services provided outside our office are billed separately. We do not handle any of the lab billing. If you have questions or concerns about a bill from the lab you must contact them directly.

12. Orthopedic supplies, supplements, food and other retail items provided by our office are not covered by insurance and will not be billed to the insurance company (some exceptions may apply). Payment is expected at the time of purchase.

13. Method of payment you plan to use to take care of today's charges, if any?

❑ Cash ❑ Check ❑ Visa/MasterCard/Discover/AMEX

I _____ understand and agree that health and accident
(Print name)
insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Alpine Wellness Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Alpine Wellness Chiropractic will be credited to my account upon receipt. *However,* I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Alpine Wellness Chiropractic to obtain a credit report if deemed necessary.

_____

Patient Signature Date

PRE-NATAL NEW PATIENT FORMS

Please print clearly

Name:_____

ASSIGNMENT AND MEDICAL INFORMATION RELEASE FORM

This form will help us coordinate the exchange of information and release of 3rd party reimbursement.

Assignment of Insurance Benefits and Payment Guarantee

I, _____ (Patient) assign to Alpine Wellness Chiropractic and/or Dr. Denesa Pozner (AWC) any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by AWC. Patient also assigns to AWC any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by AWC. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare cost to make all payments for healthcare services rendered by AWC directly to AWC.

Release of Information

Patient herby authorizes AWC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all test of any type or character of patients such persons as MHC deems appropriate.

Please provide Primary Care Physician's information:

Doctor's Name: _____

Office/ Clinic Name: _____

Address: _____

_____

Clinic Phone Number:_____

Doctor's E-mail: _____

Specialty or scope of practice: _____

If referred by specialist please provide their information as well:

Doctor's Name: _____

Office/ Clinic Name: _____

Address: _____

_____

Clinic Phone Number:_____

Doctor's E-mail: _____

Specialty or scope of practice: _____

(Please do not neglect to fill in your Doctor's information)

_____ _____

Signature of Insured / Guardian Please Print Name

_____

Date

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 28, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour (with a minimum of $20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us. Contact Officer: Denesa Pozner, DC. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Denesa Pozner, DC

Alpine Wellness Chiropractic, 16205 W. 64th Ave., Ste. B-1, Arvada, CO 80007 Phone: 303.431.8558 Fax: 303.431.9232

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____ , have received a copy of this office's

Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____

_____

_____

_____