Whole Health Chiropractic

HIPAA Acknowledgement

(Please print)

Name: ______________________________ **Date of Birth:** ______________

Mailing Address: ____

At which of the following phone number(s) do we have permission to contact you?

○ Home ______________________ May we leave a message for you at home?
□ Yes □ No

○ Cell ______________________ May we leave a message for you on your cell?
□ Yes □ No

Yes / No May we text message appointment reminders?

Yes / No May we text message promotions/specials?

○ Work ______________________ May we leave a message for you at work?
□ Yes □ No

○ Other ______________________ May we leave a message for you at this number?
□ Yes □ No

Other than you or your insurance company, whom may we speak to about your healthcare information?

- ○ Spouse Name/Telephone ______________________________
- ○ Child Name/Telephone ______________________________
- ○ Parent Name/Telephone ______________________________
- ○ Other Name/Telephone ______________________________

Email ______________________________

Yes / No May we email appointment reminders?

Yes / No May we email promotions/specials?

Do you have any health information that you would like to be kept confidential from any of the people you have listed? □ Yes □ No
If so, please describe below:

____

I acknowledge that I have been given the opportunity to request restrictions on the use and/or disclosure of my protected heath information.

I acknowledge that I have been given the opportunity to request alternative means of the communication of my protected health information.

I acknowledge that I have read and signed a copy of the Privacy Notice for Whole Health Chiropractic.

______________________________ ______________

Patient or Personal Representative Signature Date

____

Relationship to Patient