Name: _____ Date: _____ File#_____

INDEK CHIROPRACTIC

Privacy Practices Acknowledgement: HIPPA

As of April 2003, all health care providers are required by law to provide you the patient with a Notice of Privacy Practices. The privacy of your protected health information (PHI) is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. You are being provided a Notice of Privacy Practices which explains how we may use and share PHI about you. If, at any time, you have questions or concerns related to your protected health information, please feel free to speak with any one of our staff.

Signature on file form

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all insurance companies related to my care at Indek Chiropractic.
- I authorize release of all medical / health information from any other provider I have used previously to Indek Chiropractic and any agent working on their behalf.
- I authorize Indek Chiropractic and any agent working on their behalf to obtain payment from my insurance company and / or attorney.
- I authorize payment to be made directly to Indek Chiropractic.
- I permit a copy of this authorization to be used in place of the original.
- I permit Indek Chiropractic and any agent working on their behalf to contact me by means of the home, work and / or cell phone number(s) I have provided on the patient information form.
- I permit Indek Chiropractic and any agent working on their behalf to contact me via written communication to my home address given on the patient information form.

I have received the Notice of Privacy Practices and have reviewed it and I have reviewed the signature on file form.

Signature: _____ Date: _____

Name printed: _____