



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Information:

Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____

Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I have been provided and received a *Notice of Privacy Practices* from Gayon High Performance Chiropractic & Rehab, Inc.

Signature: _____ Date: _____

If this Acknowledgment is signed by a parent or personal representative on behalf of Patient, please complete the following:

Parent/Representative's Name: _____
Relationship to Patient: _____
Signature: _____ Date: _____

For Office Use Only:

If unable to obtain acknowledgment from patient, describe the good faith effort to obtain patient's signature on this form: _____

If known, provide reason patient would not sign this form: _____

Signature of Clinic Staff: _____ Date: _____
Print Name: _____ Title: _____