ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of McKolosky Chiropractic's Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient Name:_____

Refused to sign ☐ Physically unable to sign☐

(Other)_____
_____
_____
_____

Employee Signature: _____ Date: _____