SPINE & SPORTS
CHIROPRACTIC CARE OF CT, LLC

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NOTICE OF PRIVACY PRACTICES
Patient Acknowledgement Form

Name of Patient ________________________________ Date of Birth______________________

Address _____________________________________ City/State/Zip ______________________

I hereby acknowledge that I received a copy of this medical practice Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I can request a copy of any amended Notice of Privacy Practices.

Signature __________________________________ Date ____________________

If not signed by patient, indicate relationship to the patient _________________________

HIPAA CALLING INFORMATION

With whom do you allow us to share your personal medical information at your home or elsewhere?

Name __________________________________ Relationship _________________

Name __________________________________ Relationship _________________

Is there anyone you do NOT want us to share your medical information with at your home or elsewhere?

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How may we contact you?

Home Phone # ___________________ Cell Phone # ____________________

Do NOT leave a message ☐ Do Not leave a message ☐

Leave a message but with little detail ☐ Leave a message but with little detail ☐

Work Phone # ___________________

Do NOT leave a message ☐

Leave a message but with little detail ☐