

**AMERICAN INTEGRATED CHIROPRACTIC
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____ (print name), acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of American Integrated Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Signature

Date

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

American Integrated Chiropractic has made a good-faith effort to obtain an acknowledgment of _____ (patient's name) receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

Patient Unavailable
Patient Physically Unable
Patient Unwilling

In an effort to obtain the patient's acknowledgment, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner (check all that apply):

In Person
Mail
Phone Follow-Up
Other: _____

Physician's Signature

Date