ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_______________________________________ ________________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENTS CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice release PHI.

Name: ___________________________________ Relationship: _________________________

Appointment: Yes or No Billing: Yes or No Medical: Yes or No

Name: ___________________________________ Relationship: _________________________

Appointment: Yes or No Billing: Yes or No Medical: Yes or No

Name: ___________________________________ Relationship: _________________________

Appointment: Yes or No Billing: Yes or No Medical: Yes or No

Name: ___________________________________ Relationship: _________________________

Appointment: Yes or No Billing: Yes or No Medical: Yes or No

Hornberger Wellness & Chiropractic 4001 Swift Rd., Sarasota, FL 34231 (941) 924-4400 fax: (941) 924-4404