



Acknowledgements

Initials _____ I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ I may request a copy of the Financial Policy at any time.

Initials _____ I authorize my insurance company or administrator to pay Dynamic Spine Chiropractic Health Center P.C. directly for the benefits otherwise payable to me under my current policy.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____ **DATE:** _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights or privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

I have reviewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

SIGNATURE: _____ **DATE:** _____

If the patient is a minor child, please print the child's full name: _____

Witness _____