



Bannard Family Chiropractic & Acupuncture, Inc.
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Dr. Daniel P. Bannard

NOTICE OF PRIVACY ACKNOWLEDGEMENT (FULL NOTICE IS AVAILABLE FOR YOUR REVIEW)

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

Conduct, plan and direct my treatment and follow-up among the multiple Health Care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (**PRINT**) _____

Signature _____

Relationship to Patient Self Parent/Guardian Other

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: Initials: Reason: