LIGHT FORCE FAMILY CHIROPRACTIC
680 DUNLAP ROAD, NE
MILLEDGEVILLE, GA 31061

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third- party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgement
- ☐ An emergency situation prevented us from obtaining Acknowledgement
- ☐ Other (Please Specify)_____

_____
Staff Signature Date