1001 E. Bogard Road
Wasilla, AK 99654

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. Please ask for your own copy, should you wish to retain it for your records.

We ask that you sign this form to acknowledge that you received our Notice of Privacy Practices.

I have received Larson Chiropractic/Back In Action Physical Therapy's Notice of Privacy Practices:

_____ _____

Print Name Date

_____

Patient's Signature or Personal Representative's Signature

_____

If Personal Representative, please describe relationship

Clinic staff should complete the following if Acknowledgement is not signed:

1. Was the patient shown a copy of the Notice of Privacy Practices? ____Yes ____No

2. If you answered "No" above, please explain why the patient did not sign an acknowledgement form and the staff's efforts in trying to obtain their signature.

   ___ Patient Unable to Comprehend
   ___ Patient Communication Barrier
   ___ Legal Rep. Not Available
   ___ Other:_____
   ___ Patient Left before Signature Obtained
   ___ Emergency Admission/ Patient Not Present
   ___ Patient Bypassed Registration-Not Available

Completed By:

_____ _____ _____

Staff Member Signature Title Date

Revised 6/16/14