



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.

We ask that you sign this form to acknowledge that you received a copy of 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. Does the patient have 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.

- | | |
|--|--|
| <input type="checkbox"/> Patient Unable to Comprehend | <input type="checkbox"/> Patient Left before Signature Obtained |
| <input type="checkbox"/> Patient Communication Barrier | <input type="checkbox"/> Emergency Admission/ Patient Not Present |
| <input type="checkbox"/> Legal Rep. Not Available | <input type="checkbox"/> Patient Bypassed Registration-Not Available |
| <input type="checkbox"/> Other: _____ | |

Completed By:

Staff Member Signature

Title

Date