

PRIVACY PRACTICES
PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Alternative Care Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature / Guardian Signature

Date

Print the Patient's Name

Print the Guardian's Name