ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I________________________(patient name), acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of All Natural Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received and maintained by the Practice.

I authorize ________________________________ **(name of patient representative**) to receive information regarding my care limited to: (Please indicate ☐ Y – Yes or ☐ N - No

☐ Y ☐ N Appointments ☐ Y ☐ N Billing ☐ Y ☐ N Protected Health Information

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_______(Please Initial if you authorize) I hereby give my consent and state my preference to have my physician, Dr. Mark Jacobs and other staff at All Natural Chiropractic communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my healthcare which may include, but shall not be limited to appointments and billing and protected health. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be unsecure. I further understand that , because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party. Communications are not necessarily encrypted.

Appointment reminders and private health information will be communicated to you only in manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be unsecure.

Please choose one of the following selections:

1)______I give my permission to leave appointment, billing and private health information at the following (please complete the ones you agree to):

*Phone number*________________________________ *Alternate Phone number:*____________________________

*Email address*_________________________________

*Text number*__________________________________

OR

2)______I give my permission to contact me relative to only appointment reminders and billing by the following methods:

*Phone message number*________________________ *Alternate message number*____________________________

Email address ________________________________

*Text messages*________________________________

______________________ ____________________________________

Date Patient Signature

Any and all permissions may be revoked or changed by patients at any time by completing a new Acknowledgement of Privacy Practices Agreement.

Office Use Only: If notice is not provided to patient: In an effort to obtain the patient's acknowledgment, a representative of All Natural Chiropractic has attempted to provide the Acknowledgment of Privacy Practices by mail.

__________________ ____________________________ __________________________

Date *Printed Name* *Signature*