

**FELICIJAN CHIROPRACTIC OFFICE**  
**124 2<sup>nd</sup> St**  
**Pardeeville, WI 53954**  
**608-429-3323**

**Acknowledgement of Receipt of  
Notice of Privacy Practices**

*This form will be retained in your medical record.*

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**NOTICE TO PATIENT**

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We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of FELICIJAN CHIROPRACTIC OFFICE.

I understand that the Notice describes the uses and disclosures of my protected health information by FELICIJAN CHIROPRACTIC OFFICE and informs me of my rights with respect to my protected health information.

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*Patient's Signature or that of Legal Representative*

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*Printed Name of Patient or that of Legal Representative*

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*Today's Date*

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*If Legal Representative, Indicate Relationship*

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**FOR OFFICE USE ONLY**

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We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement
- Communications barriers prohibited obtaining the acknowledgement
- Other (please specify): \_\_\_\_\_

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*Employee Name*

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*Today's Date*