**Notice of Privacy Practices Acknowledgement**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

PATIENT INFORMATION RELEASE CONSENT FORM

Nielsen Chiropractic Health Center is requesting **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print patient’s name)** to provide consent to release confidential healthcare information to:

● Insurance, Employer, School, Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

● Family Members, and/or Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purpose of patient care and the billing of patient care when providing needed healthcare treatment, to obtain payment for healthcare services, for healthcare operations, or to determine eligibility for employment.

**CONDITIONS:**

* The patient has the right to request that this facility maintain his/her healthcare information as confidential.
* The patient has the right to review the facility’s policy regarding the use of confidential patient healthcare information without the patient’s consent.
* This facility reserves the right to either honor or dismiss the patient’s request to limit the use of the patient’s healthcare information.
* Should this facility agree to the patient’s restrictions on providing confidential healthcare information, the request will be maintained by this facility.
* The patient has the right to revoke this consent at any time. Revoking of this consent must be done in writing, signed, and dated.
* This consent is between Nielsen Chiropractic Health Center and the above-mentioned patient**.** No other individual/organizations have permission to obtain the patient’s confidential healthcare information under this consent.
* This consent form will be stored at this facility.

**Patient Text Appointment Reminders**

This is a courtesy to help you remember. If cell service or internet is down, then the reminder may not go out. If you do not show up for your appointment without calling to cancel or rescheduling within 2 hours prior to your appointment time, you will be subject to a charge that can be up to an office call fee. Keep in mind that there are a lot of people out there hurting and may have been denied an appointment due to a full schedule. If you do not call to cancel, then we cannot offer that spot to someone else. Please be courteous and let us know if you are not going to make it.

I have read the above statements and take responsibility for my appointments scheduled. Please check one of the boxes below that applies.

* Prior to my appointment, I would like to receive a text message (select one box):

🞎 4 hours 🞎 the Day before (Cricket and Pioneer are done the day before)

Service provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I would like to receive emails prior to my appointments. I would like to receive an email (select one box):

🞎 4 hours 🞎 the Day before My email address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I would NOT like to receive text message reminders for my appointments and will remember them on my own.

**I HAVE READ THIS FORM IN ITS ENTIRETY AND UNDERSTAND THE PRIVACY PRACTICES, CONSENT FOR RELEASE, AND APPOINTMENT REMINDERS.**

**Signature of Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_