RIEBESELL CHIROPRACTIC CENTER

1001 CROSSPOINTE DRIVE - SUITE 1
NAPLES, FLORIDA 34110
239-592-0304

PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Assist in obtaining reimbursements from third-party payers (your insurance company) on your behalf.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its privacy notice and that I may contact this organization any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is to be used or disclosed. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I WISH TO BE CONTACTED

REGARDING MY APPOINTMENT, BILLING, OR MEDICAL CARE IN THE FOLLOWING MANNER

☐ **HOME PHONE NUMBER** _____

☐ **OK** TO LEAVE A MESSAGE ☐ **DO NOT** LEAVE A MESSAGE

☐ **WORK PHONE NUMBER** _____

☐ **LEAVE MESSAGE WITH CALL BACK NUMBER ONLY** ☐ **OK TO LEAVE A MESSAGE**

☐ **CELL PHONE NUMBER** _____

☐ **OK TO LEAVE DETAILED MESSAGE** ☐ **LEAVE CALL BACK NUMBER ONLY)**

☐ **WRITTEN COMMUNICATION ONLY**
(WILL SEND TO HOME ADDRESS UNLESS REQUESTED DIFFERENTLY

☐ **EMAIL/OTHER** _____

I AUTHORIZE THE FOLLOWING PERSONS TO BE CONTACTED REGARDING MY APPOINTMENTS, BILLING OR MEDICAL CARE.
(WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED HERE)

NAME _____ **RELATIONSHIP**_____ **PHONE**_____

NAME _____ **RELATIONSHIP**_____ **PHONE**_____

NAME _____ **RELATIONSHIP**_____ **PHONE**_____

PATIENT NAME _____
PRINTED

PATIENT SIGNATURE _____ **DATE**_____