Pro-Health Chiropractic & Integrative Center
Bruno Da Rocha, DC, CCSP
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PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL:
1) May we confirm your appointments by email, text or phone? Yes No

2) May we leave a message on your answering device at home or cell phone? Yes No

3) May we discuss your condition with any members of your family? Yes No
If yes, provide names: _____

4) We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested. Are you comfortable being treated in an open room? Yes No

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____ _____
Patient Printed Name Patient Signature or legal representative

_____ _____
Date If legal representative, state relationship

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date