

Patient Privacy and Acknowledgement Statement

File# _____

Part I – Acknowledgement Statement

I, the undersigned, hereby acknowledge that I have provided Reisterstown Family Chiropractic certain specific Protected Health Information, here after referred to as PHI. This information is provided by me, with the understanding that it will be used for these purposes only:

- 1-Diagnosis and treatment of my spinal complaints.
- 2-Billing my insurance carrier
- 3-Providing requested information to my insurance carrier, this may include: Treatment notes, X-ray findings, examination or evaluation findings and reports.
- 4-Notifying me of future or missed appointments, by phone, U.S Postal service, or e-mail
- 5- Announcing or informing me of Practice Events, such as Patient Appreciation Days, special promotion, etc.
- 6-By Subpoena, court order, or other Legal requiems

I understand that Reisterstown Family Chiropractic provides a sign in sheet daily. This sign in sheet is accessible to Staff members and other Patients entering this office seeking treatment. I also understand that Reisterstown Family Chiropractic displays the names of Patients that refer in other Patients in the Waiting Area. I agree that my name maybe used for this purpose should I refer in a Patient, unless I have provided a request to the contrary in writing.

Part II- My Rights as Patient

I have the right to:

- 1-Revoke this authorization at anytime, by submitting a written request for such to Reisterstown Family Chiropractic's Appointed Privacy Officer.
- 2-Request restriction of specific information or disclosure. This request must be made in writing and submitted to Reisterstown Family Chiropractic's Appointed Privacy Officer.
- 3-Inspect or copy any PHI. This request must be made in writing and submitted to Reisterstown Family Chiropractic's Appointed Privacy Officer.
- 4-Amend my PHI at anytime, as provided by law. All amendments will be made in writing.
- 5-Receive an accounting of any and all disclosures
- 6-Contact Reisterstown Family Chiropractic's Appointed Privacy Officer at any time with concerns or complaints. This contact may be done in Person, via phone @ 410-517-2400, via U.S. Postal Service or via E-mail @ rfchirodoc@dcfirst.com.

Part III- Reisterstown Family Chiropractic's Responsibilities

In accordance with Federal HIPAA Laws and Maryland State Privacy Laws, Reisterstown Family Chiropractic is required to:

- 1-Abide by all Federal and Maryland State Privacy laws and regulations
- 2-Maintain my Chiropractic and financial records in a discrete and secure location within their office.
- 3-Notify me in writing of any changes to this acknowledgement, and provide for my signature in a timely fashion an amended statement for my signature.

By subscribing my signature below, I acknowledge receipt of this notice and understand and agree to its terms.

(Signature of Patient or Guardian)

(Date)

(Signature of Staff Witness)

(Title)

My initials below signify that I have received a copy of my signed agreement for my personal records.
