

RECEIPT OF NOTICE OF PRIVACY POLICIES

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

Our commitment here at ACT Wellness Center By Accredited Chiropractic (ACT) is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information (PHI). We here at ACT are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Policies. During the course of serving your interests it may be necessary to share information such as treatment, payment and healthcare operations with other Health Care Providers or Business Associated. For payment purposes, we do electronic billing; your information is protected by a firewall system. Your file is a personal record and will not be released without your signature.

With my consent, ACT may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ACT's Notice of Privacy Practices for a more complete description of such uses and disclosures. **I have the right to review the Notice of Privacy Practices prior to signing this consent.** ACT reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ACT's Privacy Officer, Christina Caratozzolo at 13820 Smoketown Rd., Woodbridge, VA 22192 / (703) 897-8400 / Fax: (703) 590-1294.

With my consent, ACT may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Also, ACT may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. ACT may e- mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements During treatment, if you feel the need for a private adjustment ACT can accommodate.

I have the right to request that ACT restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. As provided for by law, I may revoke this written authorization at any time. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ACT may decline to provide treatment to me.

If you have any questions, comments or concerns regarding your Protected Health Information, feel free to contact our Compliance Officer, Christina Caratozzolo at (703) 897-8400.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES
"You May Refuse to Sign This Acknowledgement"**

I have read, understand and received or reviewed a copy of the Notice of Privacy Policies for Accredited Chiropractic & Therapeutic Massage. By signing this form, I am consenting to ACT's use and disclosure of my PHI to carry out TPO.

Patient name _____ Date of birth _____ Phone _____

Signature

Date

Parent / Guardian Signature

Date

Comments, if any: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): _____