Ciarrocca Chiropractic Center
Kenneth J. Ciarrocca, D.C.
Ph#: 908-654-0566 Fax#: 908-654-8574

Patient Name:_____ **Date of Birth:**_____

Acknowledgement of Notice of Privacy Practices

We keep a record of every healthcare service treatment provided to you within our office. You may ask for a copy of your records under the current laws. We will not disclose your record to others unless you have directly expressed us to do so in writing or unless the law authorizes or compels us to do so. If you are being represented by a legal representative or an attorney, or would like our office to release your information to another business entity, you must also state so in writing and your request will be honored based on our office policy timeline.

I have read and acknowledge the above notice and the office procedures & policies and agree.

_____ _____

Signature or legal representative **Date**

_____

Printed Name

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and medical information to you in confidence. In order to protect your privacy and confidentiality of your information while abiding by the law, please complete below. This will state how you wish to be contacted by our office and to whom we may discuss your health care with:

You may contact me at the following phone numbers & e-mail address:(Provide all that apply)

Home#: _____ Work#: _____ Cell#: _____

Home E-mail Address: _____

Work E-mail Address: _____

__ Yes, you may leave a confidential message at __Home __Cell __Work(Check all that apply)

__ Yes, you may leave the you may leave a message containing the necessary information on my answering machine, voicemail, or e-mail listed above.

I authorize Ciarrocca Chiropractic Center staff to disclose my Protected Health Information (PHI) to the designated person(s) listed below because such person is involved with my healthcare or payment relating to my healthcare. Ciarrocca Chiropractic Center staff will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare. Ciarrocca Chiropractic Center staff is not responsible should the authorized individual(s) further disclose my protected PHI.

_____ Yes, I _____, designate the persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of Ciarrocca Chiropractic Center making the disclosure as described in their forms. I understand that I am not required to list anyone. I further understand that if the patient is a minor with a parent or guardian signing this form for them, they will sign a new one upon reaching the legal age of 18 years old as they will become an adult an are the only ones to authorize any action on this account.

Names: **PH#s:** **Relationship**

1._____

2._____

3._____

Our office will continue to communicate with you accordingly to your above response(s) choices until you change your preferences. You may do so by completing a new form By signing below, you grant permission to the communication outlined above to begin immediately.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Printed Name **Relationship**