ELITE Chiropractic & Injury Rehab
2150 Commercial St SE, Suite 10
Salem, Oregon 97302
Phone: 971-707-4706
Fax: 971-707-4705

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient# or SSN: _____

Address:_____ City:_____ State:_____ ZIP:_____

Email:_____ Phone: (____)_____-_____ Cell/Home/Wk

I have been provided or offered a copy of the Notice of Privacy Practices of ELITE Chiropractic & Injury Rehab, which describes how my health information is used and shared. I understand that ELITE Chiropractic & Injury Rehab has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official or by visiting the Facility website at www.beelitechiropractic.com.

My signature below acknowledges that I have been provided or offered a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Printed Name

_____

Personal Representative's Title ***(e.g. Guardian, Executor of Estate, Health Care Power of Attorney)***

For Clinic Use Only:* *Complete this section if you are unable to obtain a signature.

1. If the Patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:
   _____
   _____
2. Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

Completed by:

_____ _____

Signature of Clinic Representative Date

_____

Printed Name

Scan or file original in Patient's Records.