



& INJURY REHAB

ELITE Chiropractic & Injury Rehab
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Phone: 971-707-4706
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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