Health WEBB LLC
FAMILY CHIROPRACTIC AND WELLNESS

**Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information & Permission to Contact and Release of Information Health Webb LLC**

**Print Patient's Name: ___________________________________________ Date ______________________**

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

In order to improve communications between the office and our patients, we will be contacting you to confirm your appointment(s). Please check only (1) box below to indicate your preference for appointment reminders (* Message and Data rates may apply):

◊ Voice (please provide phone # in the next section below)

◊Text (if text, please provide your cell carrier & provide your phone # in the next section below):
____________________________________________________________________________________________________

◊ Email
____________________________________________________________________________________________________

Also, there may be times when we need to speak to you personally regarding your appointment or to discuss your confidential health information. Please provide how and where you would like to be contacted. Please Check the diamond below to indicate your preference.

Please contact me at: HOME# ____________________ CELL#_____________________WORK#_________________

◊ I authorize you to leave normal test results only on my voicemail

◊I request that you leave a message on my voicemail but only to indicate you have called, and I will return your call

◊You may at any time release my confidential health information to: (if no one, please write NO ONE)

Name:__________________________________ Relationship to patient _______________ Phone #/Type___________

Name:__________________________________ Relationship to patient _______________ Phone #/Type___________

____________________________________________________________________________________________________

Signature of Patient/Guardian/Parent Printed Name Date



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