Belleville Chiropractic and Wellness Center
PH: (608) 424 1840

1100 Bellwest Blvd
Belleville, WI 53508
Fax: (608) 424 1815

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this offices Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and accreditation.

Please print name: _____

Please sign name: _____

Date: _____

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
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify) _____

Staff signature: _____ Date: _____