TOTAL HEALTH CHIROPRACTIC, LLC

DBA Total Health Wellness Center

566-A Union Avenue, Bridgewater, NJ 08807

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Total Health Chiropractic, LLC, doing business as **Total Health Wellness Center**, is committed to protecting the privacy and confidentiality of your health information in accordance with applicable federal and state privacy laws.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

I understand that Total Health Wellness Center may use and disclose my protected health information (PHI), as permitted or required by law, for purposes including:

Treatment — Providing, coordinating, or managing my healthcare and communicating with other healthcare providers involved in my care.

Payment — Billing and obtaining payment for healthcare services provided to me, including communications with health plans, insurance carriers, and other responsible parties.

Healthcare Operations — Activities necessary to operate the practice, including administrative functions, quality assessment, compliance activities, and other healthcare operations permitted by law.

I understand that certain other uses and disclosures of my protected health information may require my written authorization unless otherwise permitted or required by law.

MY PRIVACY RIGHTS

I understand that I have certain rights regarding my protected health information, as explained more fully in Total Health Wellness Center's **Notice of Privacy Practices**.

These rights include, as applicable, the right to:

- Inspect and obtain a copy of certain health information maintained about me;
- Request a correction or amendment to certain health information;
- Request confidential communications in a particular manner or at a particular location;
- Request certain restrictions on the use or disclosure of my health information;
- Request an accounting of certain disclosures of my health information;
- Obtain a paper copy of the Notice of Privacy Practices;
- Choose someone who is legally authorized to act on my behalf regarding my health information; and
- File a complaint if I believe my privacy rights have been violated.

I understand that Total Health Wellness Center is not required to agree to every requested restriction, except when otherwise required by law.

ACKNOWLEDGMENT

I acknowledge that I have received, or have been given the opportunity to receive, a copy of **Total Health Wellness Center's Notice of Privacy Practices**.

I understand that the Notice explains how my protected health information may be used and disclosed, describes my privacy rights, and explains the responsibilities of Total Health Wellness Center regarding the privacy and security of my health information.

I understand that I may request a current copy of the Notice of Privacy Practices at any time.

Patient Name (Print): _____

Patient/Guardian Signature: _____ **Date:** _____

If signed by someone other than the patient:

Name of Parent/Guardian/Personal Representative: _____

Relationship to Patient: _____

Staff/Witness: _____ **Date:** _____

FOR OFFICE USE ONLY

☐ Patient/Representative received a copy of the Notice of Privacy Practices.

☐ Patient/Representative was offered a copy of the Notice of Privacy Practices.

☐ Patient/Representative declined to sign the acknowledgment.

☐ Patient/Representative was unable to sign.

If acknowledgment was not obtained, document the reason and the good-faith effort made to obtain it:

Staff Initials: _____ **Date:** _____