SCOMA CHIROPRACTIC, P.A.

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HOURS BY APPOINTMENT

HEALTH AND WELLNESS CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices and that it is available for me to take. I have read the Notice or have declined the opportunity to read it. I understand the Notice of Privacy Practices. I understand that this form will be placed in my patient file and maintained for 6 years.

By checking the lines below I authorize Scoma Chiropractic P.A. to contact me by the following methods for announcements, greetings, promotions, appointments and other communication.

Yes

1. _____ E-mail-_____
2. _____Phone/ voice mail-_____
3. _____Text/ Cell phone-_____

_____ _____

Patient Name Date

_____

Signature