

**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices provided by Arola Chiropractic & Acupuncture and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND
MAINTAINED FOR SIX YEARS.**