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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1. CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
2. OBTAIN PAYMENT FROM THIRD PARTY PAYERS.
3. CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIANS CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS HEALTH CARE OFFICE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICE FROM TIME TO TIME AND THAT I MAY CONTACT THIS HEALTH CARE OFFICE AT ANY TIME AT THE ADDRESS ABOVE TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVATE PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENTS NAME _____

RELATIONSHIP TO PATIENT _____

SIGNATURE _____

DATE _____

OFFICE USE: REASON UNABLE TO OBTAIN SIGNATURE _____

INITIALS _____ DATE _____