FOUR POINTS FAMILY CHIROPRACTIC
DR. ROSS COCCIMIGLIO
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We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 (HIPAA), we are required to inform you of our privacy policies and procedures. We encourage you to read the document carefully for it outlines the use and limitations of the disclosure of your health information and your rights as a patient (located on the wall at our front desk). If you have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

PLACE A CHECK MARK ON THE ACTIONS THAT APPLY

I, _____, give **Four Points Family Chiropractic, PLLC** permission to use or post my name in the office for the following reasons:

___ Acknowledging referrals
___ Promos/contests/special events
___ Birthday card sent home/announcement
___ Personal Testimonial
___ Welcome/Greeting/Introductions
___ Photo/kid's photos
___ Receiving Emails
___ I **DO NOT** want my name posted/used in the office for any reason.

~~~~~**There may be an occasion when we have to phone you** ~~~~~

I, _____, allow **Four Points Family Chiropractic, PLLC** to:

___ Call me at home
___ Call me at work
___ Leave a message at home
___ Leave a message at work
___ Contact me by cellular phone

I acknowledge that I have been informed of the **Four Points Family Chiropractic, PLLC.** Notice of Privacy Practices for Protected Health Information.

Patient Name_____ Date_____

Signature_____

If patient is under 18, _____ is legal guardian for _____,

_____, _____ , _____.
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