ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.
I, _____, hereby acknowledge that Flow Chiropractic PDX/Dr. Kelly Coogan has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:
Flow Chiropractic PDX 9643 SE Tenino Ct, Happy Valley, Or, 97086.

I also understand that I am entitled to receive updates upon request if Flow Chiropractic PDX/ Kelly Coogan DC amends or changes its Notice of Privacy Practices in a material way.

_____
Signature & Relationship to Patient (if signed by someone other than patient)

Date_____.

***I also understand that if I need to cancel, I will give at least 24 hour notice to allow other patients to have that appointment time.

signature_____