Dr. PIERRE ROUSSE, LLC

Chiropractor
5425 Peachtree Parkway
Peachtree Corners, GA. 30092
Office: (678) 906-2800

ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our Notice of Privacy Practices. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations. This applies to the privacy practices of DR. PIERRE ROUSSE, LLC and all affiliated covered entities of DR. PIERRE ROUSSE, LLC issuing this Notice. You have the right to review our Notice of Privacy Practices prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. By signing this form, you acknowledge you have received our Notice of Privacy Practices and that DR. PIERRE ROUSSE, LLC. and all affiliated covered entities can use and disclose your protected health information in accordance with HIPAA.

Signature of individual or surrogate decision maker

___________________________	______________________________	______________
FULL NAME	*SIGNATURE*	*DATE*

Relationship to resident/patient/legal authority (if applicable)

___________________________	______________________________	______________
FULL NAME	*SIGNATURE*	*DATE*

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Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of ____________________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

I prefer to be called at:

1. Home # ____________________________
2. Cell # ____________________________
3. Work # ____________________________

____
Patient name printed

____
Date

____
Patient Signature

____
Authorized provider representative

____
Personal representative Printed

____
Personal representative signature

____
Description of personal representative's authority to act for the patient