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NOTICE OF PRIVACY PRACTICES

I acknowledge that Lupo Chiropractic Center's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Lupo Chiropractic Center's Notice of Privacy Practices prior to signing this document. Lupo Chiropractic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lupo Chiropractic Center. The Notice of Privacy Practices for is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Lupo Chiropractic Center's duties with respect to my protected health information.

Lupo Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name _____

Patient Signature _____ Date _____