



Hoffman Chiropractic

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Acknowledgement of Notice

I acknowledge that the Notice of Privacy Practices for Hoffman Chiropractic Clinic. (Notice) has been made available to me.

I understand that I have the right to review the Notice prior to signing this document. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and/or the performance of healthcare operations at Hoffman Chiropractic Clinic.

Hoffman Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice. I understand that I may obtain a revised Notice at www.hoffmanhealth.com by calling and requesting a copy by mail, or by picking one up at one of the offices.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date