



A TOUCH *of* THERAPY

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to A Touch of Therapy's (AToT) "Notice of Privacy Practices". I understand that I have the right to review AToT's "Notice of Privacy Practices" prior to signing this document.

I understand that AToT staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners or AToT. By signing this form, I am giving AToT authorization to contact me with these reminders and to utilize my information for research and educational purposes.

Patient Name (print)

Date

Patient Signature

AToT Privacy Rep/Date