Ash Chiropractic & Acupuncture Clinic

Ashraf A. Soomar-Kheraj, B.S., D.C.

Notice of Office's Privacy Practices

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice of Privacy, please contact any staff member in our office.

By signing this, I am acknowledging that I have been provided a copy of the Office's Privacy Practices.

_____	_____	_____	_____
Patient Signature:	Patient's Name (Print):	Date:	PIN #:
_____	_____	_____	_____
Parent or Guardian's Signature:	Parent or Guardian's Name (Print):	Date:	Dr. Initials:
_____	_____	_____	_____
Witness' Signature:	Witness' Name (Print):	Date:	Dr. Initials:

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