

Dr. Robert DeVincentis  
Intracoastal Chiropractic Clinic  
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**ACKNOWLEDGEMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian or Patient's Legal Representative

\_\_\_\_\_  
Signature

**This Form Will Be Placed In The Patient's  
Chart and Maintained For Six Years**