



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____ Social Security # _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we will try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

I have received the Notice of Privacy Practices (effective date: January 17, 2014).

Patient's (or Legal Representative's) Signature)

Date

Relationship of Legal Representative

For office use only

To be completed only if Acknowledgement is not signed.

1. Was the patient given a copy of the Notice of Privacy Practices?

Yes No

2. Please explain why the patient was unable to sign the Acknowledgement and our efforts to obtain the patient's signature:
