ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that you are not required to agree to my requested restriction, but if you agree that you are bound to abide by such restriction.

Patient Name (print) _____

Relationship to Patient _____

Signature _____ Date _____

How would you like us to communicate with you?

Patient Name (print) _____ Date of Birth _____

Address _____

If the address provided above is not your home address or if it is not a street address, please provide us with a street address for purposes of ensuring payment and/or written communications.

Home # _____ May we leave a message? Yes _____ No_____

Work# _____ May we leave a message? Yes _____ No_____

Cell # _____ May we leave a message? Yes _____ No_____

Email _____ May we leave a message? Yes _____ No _____

May we send an appointment reminder text message? Yes _____ No _____

May we leave a message that you need pre-medication? Yes _____ No _____

I do not want a reminder left at all _____ (initials) I do not want a postcard sent _____ (initials)

VERBAL AND WRITTEN COMMUNICATION

I _____ give permission of written or verbal communication to _____.

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices* but was unable to do so as document below.

Date _____ Reason _____ Initials _____