ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, this organization creates and maintains health records describing my health, history, symptoms, examination and test results, diagnoses, and treatment pertaining to my diagnoses. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication for among the health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer (e.g. insurance carrier) can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and outcomes

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

Our Notice of Privacy Practices is subject to change. If we change our notice, we will provide you with an updated notice.

____________________________ ____________________
Patient's Signature Date

____
Please Print patient's name

____________________________ ____________________
Witness Date

Acknowledgment of Receipt of Notice of Privacy Practices was not signed as noted below:

- o Patient Refused to Sign