HIPAA COMPLIANT

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT

I understand that The 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:

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

I acknowledge that I have received or been given a chance to read the "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" from time to time and that I made contact with this organization at any time at the address below to obtain a current copy of "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 healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agreed, then you are bound to abide by such restrictions.

Patient Name:_____ Relationship to Patient:_____

Signature:_____ Today's Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature and acknowledgment on this notice of privacy, practice acknowledgment, but wasn't able to do so as documented below:

Date:_____ Initials:_____ Reason:_____