



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under 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 for these purposes.

TREATMENT

We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT

Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS

We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure 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 may contact this organization at any time to obtain a current copy of the *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 operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials/Clinician	Reason