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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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 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 assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices (NPP) 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 NPP from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NPP.

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 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.

Client name (please print): _____

Relationship to client: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgment on this NPP Acknowledgment, but was unable to do so as documented below:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented me from obtaining acknowledgment

____ Other (Please Specify) _____

Date: _____ Initials: _____