NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT FORM

I acknowledge I have received a copy of the Women's Care "Notice of Privacy Practices" (NPP). I have read and understand all of its terms as indicated and agree to comply.

Date_____**Printed Name**_____

Patient Signature _____

Responsible Party Signature (<u>required if patient is under the age of 18</u>):

_____

Printed Name of Responsible Party: _____

Relationship to Patient: _____

To be completed by office staff, if applicable:

On this date the patient presented for treatment and was provided with a copy of the practice's Notice of Privacy Practices. Although a good faith effort was made to obtain a written acknowledgement of receipt of Notice of Privacy Practices, one was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because: _____

_____

Employee (Printed Name):_____

Employee Signature:_____

Date:_____