

SIGNATURE PAGE

I have read both pages of "Policies and Procedures" carefully before signing. I agree to abide by the policies as explained. This also serves as my consent for treatment as described in this policy.

_____ Signature	_____ Date
_____ Name	_____ Date of Birth
_____ Name of Personal Representative or Legal Guardian	_____ Relationship to Patient

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Portability & Accountability Act of 1996 ("HIPPA"), 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** containing a more complete description of the users 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 may contact this organization at any time at the address below to obtain a current copy.

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.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

_____ Signature	_____ Date
_____ Name	_____ Date of Birth
_____ Name of Personal Representative or Legal Guardian	_____ Relationship to Patient

An electronic copy of this form will be retained in your medical record.