Notice of Privacy Practices Acknowledgement

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my health information. I understand this information can and will be used to:

- Conduct and direct my treatment among the mutual healthcare providers
- Obtain payment and billing for reimbursement for services and confirm coverage
- Conduct normal health care operations

I have received and read your Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

Patient / Guardian Name: _____

Signature: _____ Date: _____