RHEUMATOLOGY OF THE WOODLANDS

HIPAA ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

Notification Form

I have reviewed this office's Notice of Privacy Practices which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Relationship (if not patient): _____ Witness: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice or Privacy Practices but acknowledgment could not be obtain because:

Please indicate by using a checkmark:

_____ Individual refused to sign.

_____ Communications barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify) _____

Name of Verifying Staff Member: _____

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges included in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

My signature certifies I have read and understand the above content and this document.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____