Acknowledgement of Receipt of Notice of Privacy Practices

A copy of our Privacy Practices is available to read or take upon request.

I acknowledge that I have been offered a copy of the Montana Headache Clinic, PLLC Notice of Privacy Practices.

Name of Patient: _____Patient Date of Birth: _____

_____ _____

SIGNATURE of Patient/Patient Representative Date

_____

Relationship to Patient

***If you are a self-pay patient and DO NOT give us permission to disclose your PHI [private health information] to a health plan, please indicate by initialing here: _____

FOR OFFICE USE ONLY

Documentation of good faith efforts to obtain patient's acknowledgment that they received provider's notice of Privacy Practices

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

❒ Patient refused to sign.
❒ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
❒ Patient was unable to sign or initial because:_____
❒ Other reason (describe below):
_____

Signature: _____ Date: _____