

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You have the right to refuse to sign this Acknowledgement****

North Pointe Psychiatry, PA has provided you a copy of its Notice of Privacy Practices. The Notice of Privacy Practices explains your privacy rights as a patient and includes a complete description of the uses/or disclosures of my protected health information (PHI). 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 the treatment
- Obtain payment for that treatment
- Conduct normal healthcare operations

The Practice has explained to me that the Notice will be available to me in the future at my request and that I have a right to obtain a copy of the Notice prior to signing this consent. I have been encouraged to read the Notice carefully prior to my signing this consent.

My signature below indicates that I have been provided a copy of the Notice of Privacy Practices by North Pointe Psychiatry, PA. The Practice has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

Patient/Guardian Name (printed)

Patient/Guardian Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

- _____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other: _____

Practice Representative

Date