PRIVACY PRACTICES ACKNOWLEDGEMENT

The Neuropsychology Center

6000 Shakerag Hill, Suite 216
Peachtree City, GA 30269
Telephone: 770-632-1088
Fax: 770-632-2088

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my Neuropsychologist's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***Notice of Privacy Practices.*** I understand that my Neuropsychologist has the right to change the ***Notice of Privacy Practices*** and that I may contact this office at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____
(please print)

Signature: _____

Relationship to Patient: _____
(If Applicable)

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FOR OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign

☐ Communication barriers

☐ Emergency situation

☐ Other