ACKNOWLEDGEMENT FORM

Patient Name _____ **Date of Birth** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have been offered a printed copy of the *Notice of Privacy Practices* by Primary Pediatrics, P.C. This *Notice of Privacy Practices* is for the purpose of providing you the information about how Primary Pediatrics, P.C. may use and disclose your protected health information. It is recommended that you read the *Notice of Privacy Practices* carefully. Primary Pediatrics, P.C. reserves the right to revise and materially change the contents of its *Notice of Privacy Practices*. To obtain the most current version of Primary Pediatrics, P.C. *Notice of Privacy Practices*, you may visit our website at www.primarypediatrics.com or by contacting our office at any time.

I acknowledge that I have been offered a printed copy of the *Notice of Privacy Practices* of Primary Pediatrics, P.C.

_____ _____

Signature of patient/parent/conservator/legal guardian Date

INABLITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.

_____ _____

Signature of Provider Representative Date

Reasons why acknowledgement was not obtained:

☐ Patient/Patient Representative Refused to Sign ☐ Other: _____

Comments:

_____

_____

_____

_____