ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Great Lakes Neurosurgical Associates

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

- Conduct, plan and direct my treatment and follow up among the healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

A copy of our Notice of Privacy Practice will be available to be picked up at my visit.

_____

Patient's Name (Print)

_____ _____

Signature Date

_____

Relationship to Patient

(You may refuse to sign this acknowledgement)

FOR OFFICE USE ONLY

Documentation of Failure to Obtain Signed Acknowledgement

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

- ☐ Individual refused to sign (date of refusal) _____
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining the acknowledgement.
- ☐ Other (specify)_____

Attempt was made by (name) _____ Date _____