

Acknowledgement of Receipt of Notice of Privacy Practices

Practice Name: Repower Medical Clinic, LLC **Contact Person:** Donese Worden, NMD

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Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

Our Office Policies contains important information regarding payment, insurance, collections, cancellations, returns, refunds and other important information.

By signing this form, I acknowledge that I have received a copy of this office's Notice of Privacy Practices, and Office Policies. You may refuse to sign this acknowledgment, if you wish.

Patient Name / Relationship: _____

Print your Name: _____

Signature: _____

Date: _____

For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Policies from this patient but it could not be obtained because:

The Patient refused to sign We were not able to communicate with the Patient

Due to an emergency situation it was not possible to obtain a signature

Other (please provide details): _____

Employee Signature: _____ **Date:** _____