Physician Weight Loss
Phoenix • Scottsdale

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Ideal Physician Weight Loss, PLLC

I understand that under the HIPPA (Health Insurance Portability and Account and Ability 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 multiple health-care 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

By signing below, I acknowledge that I have received the notice of Private Practices with respect to my Personal health information, which explains the Legal duties and Private Practices from Ideal Physician Weight Loss. I understand that I may refuse to sign this acknowledgement.

_____ _____
Patient Signature or Patient Representative Date

_____ _____
Witness Signature Date

Office use only

Documentation of Failure to Obtain Signed Acknowledgement

On_____, I, _____ staff at
Ideal Physician Weight Loss PLLC, presented this Acknowledgement of Receipt of Notice of Privacy Practices form to patient _____

- The patient refused to provide a signature when requested.
- Communication barrier Prohibited Obtaining written acknowledgement
- An emergency situation prevented obtaining written acknowledgement
- Others (Please specify) _____