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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date : _____

Patient Name: _____ Med Rec # / Account# _____

I hereby acknowledge that I have received Notice of Privacy Practices of Provider.

Patient's Signature: _____ Date: _____

Print Name: _____ (when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).

Signature of Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____

Description of Legal Representative Authority: Parent Medical Power of Attorney (attach documentation)

Other _____ (Explain and Attach Documentation) _____

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name: _____

Date: _____

The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

Patient refused to sign acknowledgement.

Patient was unable to sign the acknowledgement because:

Other reason (describe below):

Name of Employee Completing Form: _____

Signature: _____

Date: _____