NEUROTOPIA

Neurotopia LLC

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 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.

I have received, read, and understood your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this facility has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this facility at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by these restrictions.

Patient Name: _____ **DOB:** _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's/guardian's signature on this Notice of privacy Practices Acknowledgement Form, but was unable to do so as documented below:

Date: _____ Name: _____

Reason: _____

_____

_____

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