

**PHYSICIAN'S OFFICE NOTICE OF PRIVACY PRACTICE
WRITTEN ACKNOWLEDGEMENT**

I Acknowledge:

A copy of the provider's Notice of Privacy Practice was made available to me by Center for Family Psychiatry, PLLC, located at 1235 Industrial Drive, Suite 4, Saline, Mi 48176.

The Notice of Privacy Practice was posted in a clear and prominent location within the office. I was able to read the Notice of Privacy Practice.

Furthermore, I understand that I may take home a copy of the Notice of Privacy Practice if desired

In the event that I came in for health care services in an emergency treatment situation, I was able to view the Notice of Privacy Practice as soon as reasonable practicable after the emergency treatment situation.

I have reviewed the Notice of Privacy the first day I received health care services.
I acknowledge I have the option to request a written copy for my records.

Signature of Patient

Date

D.O.B. _____

In the event that an acknowledgement is not obtained, document below provider's good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained:

Patient's Name: _____

Date of Attempt to obtain Acknowledgement: _____

Workforce Member's Name who Attempted to obtain Acknowledgement: _____

Reason Acknowledgement was not obtained (i.e., emergency treatment situation or substantial barrier to communication, etc.): _____

Signature of Workforce Member

Date

D.O.B. _____