

**HIPAA PRIVACY
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I, _____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of Dr. Holcomb & Associates (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have been provided with a copy of the Policy.

_____ [Please initial here] I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide treatment to me.

Signature of Patient

Date

For Office Use Only

I, _____ [Please print full legal name here], acting as _____ [Please print relationship to or official position with Provider] for Provider attempted to obtain the written acknowledgment of receipt of the Policy of Provider on _____ [Please insert date attempt was made], but acknowledgment could not be obtained because:

_____ [Please initial here] Patient or Patient's legal representative refused to sign.

_____ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgment.

_____ [Please initial here] Emergency circumstances prevented securing acknowledgment.

_____ [Please initial here] Other (Please specify) _____

Signature of Provider representative

Date