Acknowledgement of Notice of Privacy Practices

Patient Name: ____________________________________

I hereby acknowledge that I have received a copy of VIK Medical's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose.

____ ___________________________

Signature of Patient or Legal Representative Date

Relationship to Patient (if applicable)
_____Parent or guardian of non-emancipated minor
_____Court appointed guardian
_____Executor or administrator of decedent's estate
_____Power of Attorney

____

Printed Name of Patient's Representative (if applicable)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices on the following date __________________________, but acknowledgement could not be obtained because:

_____ Patient / Representative refused to sign

_____ Emergency situation prevented us from obtaining acknowledgment at this time. (An attempt to obtain acknowledgment will be made at a later date).

_____ Communication barriers prohibited obtaining acknowledgment (Explain)

____

_____ Other

EFF. DATE:_____________ **TERM DATE:** _____________ **COPAY:**__________ **DED:**__________

DED MET: _____________ **INSURANCE REP:** ________________ **AUTOMATED:** _____________

INTERNET:_____ **EMPLOYEE:** _____________ **INSURANCE PHONE #:**______________________