NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand, that under the Health Insurance Portability & 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 certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at (828) 670-5665 to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name: ________________________________ Date of Birth: ____________
Printed

Patient or Legally Authorized Signature: ____________________________________
Signature

Relationship to patient if signed by anyone other than the patient: ________________

____ (parent, legal guardian, etc)

Date: _______________

Should you choose not to sign this acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: