NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By my signature below I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "Notice") from Health Services, LLC ("Health Services, LLC") and that I have been provided an opportunity to review it.

I understand that I have certain rights to privacy regarding my protected health information.

I understand that Health Services, LLC can and will use my health information for purposes of my treatment, payment for treatment and health care operations.

I have read and understand that Health Services, LLC may use and share my protected health information for other purposes, as described in the Notice.

I understand that I have rights regarding my protected health information as listed in the Notice.

I understand that Health Services, LLC has the right to change the Notice from time to time and I can obtain a current copy of the Notice from Health Services, LLC at any time.

Patient/Patient's Representative Signature _____ Date _____

Patient Name (First, MI, Last): _____

Patient Date of Birth (MM/DD/YY): _____

If you are signing as the Patient's representative:

Print your name (First, MI, Last): _____

Describe your authority: _____

Internal Use Only:

Good Faith Effort to Obtain Acknowledgement Form

Patient Name: _____ Date: _____

I attempted to obtain the patient's (or their representative's) signature on this Notice of Privacy Practices Acknowledgement Form, but was unable to do so as documented below:

Reason: _____

Name: _____ Signature: _____