



Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: ____/____/____

I, _____, acknowledge and agree that I have been offered a copy of Neuroversion's **Clinic Privacy Practices.**

Signature: _____ Date: ____/____/____

Relationship to Patient (if unable to sign): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reasons:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify):

Employee name (Please print): _____ Initials: _____