NEW PATIENT QUESTIONNAIRE
Mother's Name ________________________________
Occupation ________________________________
Father's Name ________________________________
Occupation ________________________________
If adults in the household work outside the home, what child care arrangement are made for this child?

____

PREGNANCY AND BIRTH

I. Mother's age at child's birth ____________________
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins and iron? No Yes
4. Was the baby on time ______ Early? ______ Late?_____
5. Vaginal Delivery or C-section? (Circle one)
5 What was the baby's birth weight? ________________
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (Jaundice, infections, other?) No Yes
   What kind? ___________________________________

____

PAST MEDICAL HISTORY

1. Where has your child gone for well checkups until now? ___________________________
   Date of last checkup:
2. Date of last dental checkup:
3. Has your child had allergic reactions to any medications, foods, insect bites? No Yes
4. Has your child had reactions to any immunizations? No Yes
5. Any hospitalizations other than birth? No Yes
   For what? ___________________________________
6. Any serious injuries? No Yes
   What kind? __________________________________
7. Are any medications taken regularly? No Yes
   Which ones? _________________________________
8. Any prior surgeries? No Yes
   What kind? __________________________________

____

FAMILY HISTORY

1. Are the child's parents both in good health? No Yes
2. List age, sex, and general health of patient's brothers and sisters: ___________________________________

____

3. Have any of your children died? No Yes

FEEDING AND NUTRITION

1. Is your child's appetite usually good? No Yes
2. Is it good now? No Yes
3. Were there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, is he/she (was he/she) breast fed or bottle fed? ___________________________
6. If still on formula, which one do you use?____________
7. Does he/she take vitamins? No Yes

NAME: ____
DATE: ____

REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Has he/she had any problems with teeth? No Yes
3. Does he/she have frequent colds or sore throats? No Yes
4. Is there asthma, pneumonia, or recurrent cough? No Yes
5. Does he/she have a heart murmur or any heart problems? No Yes
6. Any problems with urination? No Yes
7. Any problems with diarrhea or constipation? No Yes
8. Have there been any convulsions or other problems with the nervous system? No Yes
9. Any eczema, hives, or other skin conditions? No Yes
10. Has your child ever been anemic? No Yes
11. Circle if your child has had any of the following: Nail biting, thumb sucking, bedwetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others:

____

12. Please list any other problems: ____________________

____

DEVELOPMENTAL HISTORY

1. At what age did your child sit alone?_______________
2. At what age did he/she walk alone?________________
3. Did he/she say any words by the time he/she 1 /2 years old? No Yes
4. How does this child compare to others his/her age?

____

5. Does he/she have trouble sleeping? No Yes
6. What grade is he/she in? _________________________
7. Has he/she had any trouble in school? No Yes
8. Has he/she had to repeat a grade? No Yes
9. Does he/she get along with other children? No Yes

SAFETY/ENVIRONMENT

1. (Circle) Do you live in a private house, apartment, mobile home, other?___________________________________
2. Do you know the hottest temperature of the water in the pipes? No Yes
3. Is there a working smoke alarm on each floor in the house? No Yes
4. Does your child always use a car seat/seat belt when riding in a car? No Yes
5. Are there any smokers in the household? No Yes
6. Are there any problems with the condition of your home? (Peeling paint, insects, rats, or mice) No Yes
7. Does your child always wear a helmet when riding his/her bicycle? No Yes
8. Are there any guns in the home? No Yes

Do you have a record of immunizations? No Yes

PLEASE COMPLETE ADDITIONAL HISTORY ON BACK OF THIS PAGE.

FAMILY HISTORY

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	Yes	No	Who_______________	Comments _________________
Nasal allergies	Yes	No	Who_______________	Comments _________________
Asthma	Yes	No	Who_______________	Comments _________________
Tuberculosis	Yes	No	Who_______________	Comments _________________
Heart disease (before age 50)	Yes	No	Who_______________	Comments _________________
High blood pressure (before age 50)	Yes	No	Who_______________	Comments _________________
High cholesterol	Yes	No	Who_______________	Comments _________________
Anemia	Yes	No	Who_______________	Comments _________________
Bleeding disorder	Yes	No	Who_______________	Comments _________________
Liver disease	Yes	No	Who_______________	Comments _________________
Kidney disease	Yes	No	Who_______________	Comments _________________
Diabetes (before age 50)	Yes	No	Who_______________	Comments _________________
Bed-wetting (after age 10)	Yes	No	Who_______________	Comments _________________
Epilepsy or convulsions	Yes	No	Who_______________	Comments _________________
Alcohol abuse	Yes	No	Who_______________	Comments _________________
Drug abuse	Yes	No	Who_______________	Comments _________________
Mental illness (depression, anxiety, etc)	Yes	No	Who_______________	Comments _________________
Mental retardation	Yes	No	Who_______________	Comments _________________
Immune problems, HIV, AIDS	Yes	No	Who_______________	Comments _________________
Thyroid problems	Yes	No	Who_______________	Comments _________________
Inherited illness	Yes	No	Who_______________	Comments _________________
Cancer	Yes	No	Who_______________	Comments _________________

Additional family history

____

____

____

____

____

____

PATIENT

Patient Name (Last, First, MI)	Date of Birth:	Social Security Number

Mailing Address (P0 Box, City, State, Zip)	Sex	Marital Status: ___Married ___Single ___Divorced ___Widowed ___Child ___Separated
Physical Address (Street, City, State, Zip)	Home Phone Number:	Race: ___Caucasian ___Black ___Hispanic ___Asian Other: _________________________
Employer (Name and Address)	Work Phone Number:	How did you hear about us? ___Phonebook ___Radio ___Billboard ___Friend ___Web site ___Referral Other: __________________
Spouse(Name)	Spouse SSN	Spouse Date of Birth

Spouse's Employer	Spouse Work Phone Number

Who to contact in an Emergency (name, phone number, relationship)	E-mail address:	Is this a work-related injury?

NOTE TO DIVORCED PARENTS: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills. We cannot bill the other parent Please provide information on both parents listing the person bringing the child in as the guarantor.

GUARANTOR

Guarantor Name (Last, First, MI)	Date of Birth	Sex	Social Security Number

Mailing Address (PO Box, City, State, Zip)	Home Phone Number	Work Phone Number

Employer

Other Parent Name (Last, First, MI)	Date of Birth	Sex	Social Security Number

Mailing Address	Home Phone Number	Work Phone Number

Employer

Please have all insurance cards available to be copied Primary Insurance Coverage.

Primary Insurance Coverage

INSURANCE

Policyholder Name (Last, First, MI)	Date of Birth	Sex	Social Security Number

Name of Insurance Company	Policyholder's relationship to patient	Effective Date

Insurance ID	Group #	Plan #	Employer

Address (PO Box, City, State, Zip)	Phone Number:

Secondary Insurance Coverage

INSURANCE

Policyholder Name (Last, First, MI)	Date of Birth	Sex	Social Security Number

Name of Insurance Company	Policyholder's relationship to patient	Effective Date

Insurance ID	Group #	Plan #	Employer

Address (PO Box, City, State, Zip)	Phone Number:

This is a lifetime continuing "signature on file" and consent to treat agreement and is valid until revoked by the patient in writing.

1. **Consent for Examination:**
   I hereby voluntarily present myself to Lakeshore Pediatrics for examination, treatment, injections, and medical services and/or procedures. I hereby consent to medical services deemed necessary by my provider at Lakeshore Pediatrics.

2. **Release of Medical Records:**
   I authorize Lakeshore Pediatrics to release my health information to my insurance carrier or any other person or entity responsible for paying for my healthcare services. I also authorize Lakeshore Pediatrics to use my health information for the purpose of HealthCare Operations.

3. **Benefit Assignment**
   I request payments of all authorized benefits be made on my behalf by my insurance company(s) and/or agency(s) directly to Lakeshore Pediatrics.

4. **Financial Responsibility**
   For all non-participating insurance companies and/or agencies — I understand that I remain financially responsible to Lakeshore Pediatric Center for any and all charges not paid in a reasonable time after charges are filed with the carrier; or should the carrier deny or reduce payment below the Lakeshore Pediatric Center standard charge. I am hereby notified that my insurance company and/or agency may deny payments for routine exams and procedures that they deem not medically necessary, and I agree to be personally responsible in such cases.

   For all participating insurance companies and/or agencies — I understand that I am responsible for any deductibles and/or co-insurance of allowable charges otherwise not covered. I am hereby notified that my insurance company and/or agency may deny payment for routine exams and procedures they deem not medically necessary, and I agree to be personally responsible in such cases.

5. **Consent Certification**

   I certify that I have reviewed this form and understand its contents. I also understand that this is a lifetime continuing signature on file and consent to treat agreement that is valid until canceled by me(the patient) in writing and that I have a right to receive a copy upon request.

x ________________________________ ____________________ ____________________
Signature of patient or guardian if patient is a minor Relationship to Patient Date

x ____ ______________
Address of guardian signing for patient Rcpt. Initials

OFFICE USE	LAST NAME:______________________	DOB: _____/_______/_______	CHART:__________

LAKESHORE PEDIATRIC CENTER
HIPAA PRIVACY

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION TO
FAMILY MEMBERS/CARE GIVERS/FRIENDS

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-19 1), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated there under, as amended from time to time (collectively referred to as 'HIPAA").

By signing this authorization, the patient is providing Lakeshore Pediatric Center with the appropriate authorization to discuss the patient's healthcare and payment of that healthcare with family members, caregivers and/or friends. This authorization has all of the information completed to allow Lakeshore Pediatric Center to communicate with the people you choose by completing this form. If you would like to be more specific about the information we release to your family members, please complete the general authorization form with the specifics completed on that form. This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Lakeshore Pediatric Center will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure.
YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Lakeshore Pediatric Center may use or disclose Protected Health Information (which may include but is not limited to: lab results, radiology results, medical records, hospital notes, etc...). This authorization extends to information on the use of alcohol, drugs, and tobacco; the diagnosis and treatment of HIV infection or other sexually transmitted diseases; and the diagnosis and treatment of mental illness.

By signing this authorization you agree that Lakeshore Pediatric Center or its Business Associates may disclose your personal health care information to the following person(s):

Full Name (printed)	Date of Birth	Relationship
___________________________	______/_______/______	______________________________
___________________________	______/_______/______	______________________________
___________________________	______/_______/______	______________________________
___________________________	______/_______/______	______________________________

By signing this authorization you agree that Lakeshore Pediatric Center or its Business Associates may disclose your personal health care information for the purposes of treatment, continuity of care and payment for that treatment

Expiration Date (circle one): None -or- Specific (indicate expiration date) _________/________/____________

Further, by signing this authorization, you acknowledge that you have been provided a copy of and understand Lakeshore Pediatric Center's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Lakeshore Pediatric Center has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Lakeshore Pediatric Center at its office or by sending a written request (including return address) to the following address: Privacy Officer, 275 Highway 16 North, Suite 104, Denver, NC 28037.

In accordance with your rights under and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI in the designated record set maintained by Lakeshore Pediatric Center for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time except to the extent that Lakeshore Pediatric Center has taken action in reliance on it. A revocation is effective upon receipt by Lakeshore Pediatric Center of a written request to revoke, and a copy of the executed authorization form to be revoked at the address listed above (Privacy Officer address on page 1).

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Lakeshore Pediatric Center will provide the patient with a copy of this signed authorization. Acknowledged and agreed to by the following:

PATIENT

____   ________/________/______

Signature   Date

____   ________/________/______

Full Printed Name (print)   Date of Birth

-or-

ON BEHALF OF PATIENT

____   ________/________/______

Signature   Date

____   ________/________/______

Full Printed Name (print)   Date of Birth

____

Patient’s Date of Birth

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Lakeshore Pediatric Center will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose:

____

____

____

[Describe information].

This authorization extends to information on:

- ☐ Use of alcohol, drugs and tobacco.
- ☐ The diagnosis or treatment of HIV infection or other sexually transmitted diseases.
- ☐ The diagnosis and treatment of mental illness.
- ☐

For the purpose(s) of:

____

____

____

[Describe intended use].

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to:

____

____

____

[Describe intended recipients].

Expiration Date: ____

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to Privacy Officer, 275 Highway 16 North, Suite 104, Denver, NC 28037.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide ______________________________ [name of patient] with a copy of this signed authorization.

Acknowledged and agreed to by:

PATIENT:

By____ ______________________________________
Date

Print Name____

Address:____

____

or, ON BEHALF OF PATIENT

By____ ______________________________________
Date

Print Name ____

As ____

Address: ____

____

Notice of Privacy Practices
Of
Lakeshore Pediatric Center

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. OUR RESPONSIBILITIES
Lakeshore Pediatric Center, is required by law to maintain the privacy of your protected health information and to provide you with this Notice that explains how, when and why we use and disclose your protected health information. We are required by law to follow the privacy practices that are described in this Notice. We reserve the right to change this Notice and our privacy policies at any time. Any such changes will apply to the protected health information we already have. Before we make an important change to our policies, we will change this Notice and post a new notice in our office and on our website. You can also request a copy of this Notice or any revised notice from the contact person listed in Section V. below at any time.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

Lakeshore Pediatric Center uses and discloses the health information of its patients for many different reasons. In this Notice, to "use" protected health information means that we are sharing that information with someone who is a member of Lakeshore Pediatric Center's workforce. For some disclosures, we may need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

A. Uses and Disclosures of Your Protected Health Information for Treatment Purposes Do Not Require Your Prior Written Consent. We may use and disclose your protected health information for the purpose of providing, coordinating or managing your health care and related services without obtaining your prior written consent. This means that all healthcare personnel who are involved in your care may have access to your protected health information for these purposes. For example, if your doctor refers you to a specialist for testing and treatment, we can share your protected health information with that specialist.

B. Uses of Your Protected Health information for Payment Purposes Do Not Require Your Prior Written Consent. We may use your protected health information for the purpose of getting paid for the healthcare services and items we provide to you. For example, our billing, accounts receivable and collections employees may access your protected health information for this purpose.

C. Disclosures of Your Protected Health Information for Payment Purposes Require Your Prior Written Consent. North Carolina law requires us to get your written consent to the disclosure of your protected health information for payment purposes. If you are an existing patient, you have already signed a consent allowing us to share your protected health information with your health insurance company (or any other person or entity responsible for paying for your healthcare services) for payment purposes. If you are a new patient, you will be asked to sign consent during your first visit with us. Other than an emergency situation, we can refuse treatment to any patient who does not sign a consent allowing us to share protected health information with his or her insurance company or any other person or entity responsible for paying for your healthcare services. For example, after obtaining your consent, we may send your health insurance company a copy of your physician's notes to show that the tests you received were medically necessary and thus should be covered by the health insurance policy.

D. Uses of Your Protected Health Information for our Healthcare Operations Do Not Require Your Prior Consent. We may use your protected health information in the operation of our practice for such purposes, among others, as developing procedures and protocols, reviewing the performance of your physician or other healthcare providers, training new physicians and other healthcare providers, business planning and development, and general administrative activities without your written consent. Note that this list does not include every purpose for which we might use your protected health information for our healthcare operations. For example, our human resources section may access your protected health information in order to conduct a performance review of the nurse who provides services to you at our office.

E. Disclosures of Your Protected Health Information for our Healthcare Operations Requires Your Prior Written Consent. North Carolina law requires us to get your written consent to the disclosure of your protected health information for our healthcare operations. You will be asked to sign consent during your first visit with us after January 1, 2003. Other than emergency situation, we can refuse treatment to any patient who does not sign a consent allowing us to share protected health information for our healthcare operations. For example, after obtaining your consent, we may allow an independent consultant to review your medical record as part of risk management or billing compliance audit.

F. Certain Other Uses and Disclosures Do Not Require Your Prior Written Consent. Use and disclose your protected health information without your consent or authorization for the following reasons:

I. **When disclosure is required by federal or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures of protected health information when a law requires us to report information to a government agency or to law enforcement about victims of abuse or neglect or gunshot or knife wounds, or when we receive a valid court order to produce information.

II. **For public health activities to avert a serious threat to health and safety.** For example, we report information about certain diseases (such as West Nile virus and Lyme disease) to the local health department; we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death; and we may provide information to law enforcement or another person if we believe, in good faith, that the use or disclosure is necessary to prevent serious and imminent threat to the health or safety of a person or the public.

III. **For health oversight activities.** For example, we may provide information to the government when it investigates or inspects our practice or another provider or facility.

IV. **For organ, eye or tissue donation purposes.** For example, if you agree to participate in a research study, we may provide your protected health information to the person or entity conducting the search.

V. **For certain research purposes.** For example, if you agree to participate in a research study, we may provide your protected health information to the person or entity conducting the search.

VI. **For specialized government functions.** For example, we may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter intelligence and other national security activities authorized by law.

VII. **For worker's compensation.** For example, we disclose protected health information related to your workman's compensation claim to your employer's workers' compensation insurance carrier and to your employer who is paying us to provide services to you in connection with the claim.

VIIL Appointment Reminders and Health Related Benefits or service. We may use your protected health information to provide appointment reminders to you or to give you information about treatment alternatives or other healthcare services we offer.

G. Uses and Disclosures Where You have the Opportunity to Object. We may provide protected health information to your family members, a friend or other person that you indicated is involved in your care or the payment of your health care, unless you object. In emergency situations, you will have the opportunity to object when you are able to do so. For example if you have an appointment with one of our doctors and you bring a family member with you and ask them to sit in the examination room with you while the doctor performs an examination then the doctor may disclose protected health information to that family member unless you object. Additionally, if you come to our office alone and a physician decides to admit you directly to the hospital, we may contact a family member or friend to let them know that you have been admitted to the hospital, unless you object.

H. Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections II.a. above, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose your protected health information, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent we have not already taken action relying on your authorization).

III. YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the property of and belongs to Lakeshore Pediatric Center, you have the following rights with respect to your protected health information:

A. The Right to Request Restrictions on uses and Disclosures of Your Protected Health Information. You have the right to ask us to limit how we use and disclose your protected health information. We will consider your request, but we are not legally required to accept it. If we do accept your request, we will note the accepted limitations in writing and follow those restrictions except in emergency circumstances. You may not limit the uses and disclosures that we are legally required to make.

B. The Right to Choose How We Send Protected Health Information. You have the right to ask that we send information to you to an alternate address (for example, sending information to your home address instead of your work address) or by alternate means (for example, by e-mail instead of regular mail). If we can easily provide the information in the format you request, then we must agree to your request and abide by it.

C. The Right to See and Get Copies of Your Protected health Information. In most cases you have the right to look at or get copies of your protected health information. You must make any request to look at or get copies of your protected health information in writing to the contact person identified in section V. below. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we deny your request, we must tell you, in writing our reasons for denying your request and explain to you that you have the right to have our decision reviewed and how to start the review process. If you request copies of your protected health information, we will charge $ for each page. Instead of providing the information, we may provide you with a summary or explanation and to pay the cost for it in advance.

IV. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES:

If you think we have violated your privacy rights or you disagree with a decision we made about access to your protected health information, you may file a complaint with the person listed in Section V. below. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services, 200 Independent Avenue, S.W., Washington DC, 20201. No adverse action will be taken by us against you for filing a complaint.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES:

If you have any questions about this Notice or have any complaints about our privacy practices, or would like assistance, including the appropriate forms to use, in exercising ANY OF THE RIGHTS LISTED IN section III. Above or would like to know how to file a complaint with the Secretary of the United States Department of Health and Human Services, please contact

James Ramsey
P.O. Box 677
Lincolnton, NC 28093

VI. EFFECTIVE DATE OF THIS NOTICE: This Notice is effective April 14, 2003.

Chart Number ________________

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
Lakeshore Pediatric Center

A. If Notice of Privacy Practices was hand delivered to patient, get patient to sign below OR complete part C below:

The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices of Lakeshore Pediatric Center.

____
Patient signs here

____
Print patient's name

____
Date

B. If Notice of Privacy Practices was e-mailed to patient, attach 1. Copy of e-mail and confirmation of receipt of the e-mail AND 2. Patient's written consent to receive the Notice electronically:

Patient's Name:____

C. If patient did not sign an acknowledgment of receipt of the Notice of Privacy Practices, complete the following:

1. Patient's Name: ____

2. Efforts taken to get patient's acknowledgment (include list of actions and by whom taken and date):

____

____

3. In spite of the above good faith efforts, no acknowledgment was signed by patient because (list reasons acknowledgment was not signed): ____

____

____

____

____