First Medical Care

Patient Acknowledgement Form

Patient Name: _____

(Please print.)

When you visit our practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. This practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the practice provide all of our patients with the attached "Notice of Privacy Practices" Form on their first visit. The Notice Form describes how the medical information we receive from you may be used or disclosed by the practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice Form to review. If you have questions about our privacy practices, please feel free to contact our privacy officer. Thank you for your cooperation.

I acknowledge that I have received a copy of the practice's Notice of Privacy Practices Form and have been given the opportunity to ask questions.

Signature of Patient or Personal Representative: _____

If Personal Representative, state relationship to Patient: _____

Date: _____