DRS. LOUAPRE, KOKEMOR, SARRAT & BRAEDT, L.L.C.

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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 that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provides who may be involved in that treatment, directly and indirectly.
- Obtain payment from third – payment payers.
- Conduct normal healthcare operation such as quality assessments and physicians certifications.

I hereby acknowledge that I 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 any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, nut if you do agree, then you are bound to abide by such restrictions.

Patient Name (Please Print): _____ ***Date:*** _____
Patient Signature: _____ ***Date of Birth:*** _____
If not signed by patient please indicate your relationship to the patient: Phone: _____
Name: _____ ***Signature:*** _____ ***Relationship:*** _____ ***Date:*** _____

Yes/No (Circle one) If you would like to receive a copy of any amended Notice of Privacy Practices By-E-Mail at: _____.

_____ Declined to Sign *Notice of Privacy Practices Acknowledgement*. Date____/____/_____
Patient Name:_____Patient Signature_____ DOB____/____/___

********For Office Use Only********

I attempted to obtain the patients signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below:_____
Reason for Refusal:_____Date____/____/_____ Initial_____