ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

DERMATOLOGY, P.C.

6000 University Ave #450
West Des Moines, IA 50266
515-241-2000

800 E. 1st Street #2900
Ankeny, IA 50021
515-963-9639

2006 N. 4th Street #100
Indianola, IA 50125
515-961-3880

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dermatology PC has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(es) 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 health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Employee Initials: _____ Date:_____

Reason:_____