

Client Name: _____

Client Date of Birth: _____

Acknowledgement of Notice of Privacy Practices Catalpa Health, Inc.

By signing this form, you acknowledge that we (Catalpa Health, Inc.) have given you a copy of our Notice of Privacy Practices, which explains how your health information will be handled by us in various situations. We are required under law to ask you to sign this document on the first day we provide health care services to you, whether in person or via electronic media.

If your first day of service with us is due to an emergency, we will give you our Notice of Privacy Practices, and ask you for your signature acknowledging receipt of it as soon as we can after the emergency.

I have received Catalpa Health, Inc.'s Notice of Privacy Practices

Signature of Client (if aged 14 or older)

Date

Signature of Parent/Legal Guardian

Date

Indicate your relationship to the client:

Parent Legal Guardian Self Other: _____

For office use only:

Patient Name: _____

Medical Record #: _____

Date of Birth: _____

First Date of Services: _____

Filed electronically: Yes No

Filed in patient's chart: Yes No

Time signed: ____ : ____ AM PM

