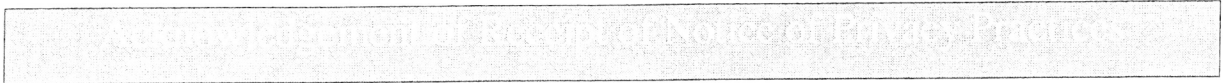


Family Health Center of Plainfield, LTD

Name of Patient: _____

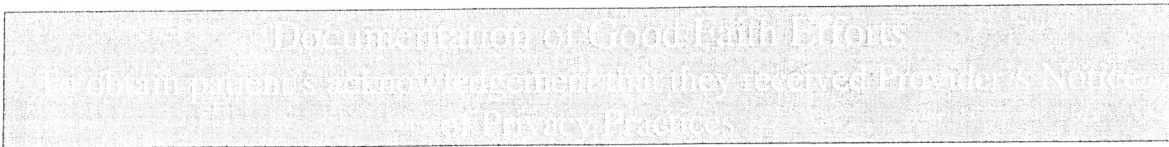
Patient Date of Birth: _____



I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices.

Signature of Patient/Guardian

Date



(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

Patient refused to sign.

Patient was unable to sign or initial because:

The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

Other reason (describe below)

Signature of employee completing form: _____

Date signed: _____