Please Complete and Bring to Your First Appointment

James K. Margolis, Ph.D..
Meredith R. Margolis, Ph.D.

INSTRUCTIONS & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

This notice of Privacy Practices includes information HIPAA Privacy Rules requires our office to give patients regarding our privacy practices. We are required to provide this notice to each patient no later than the patient's first date of service effective April 14, 2003. We must also have copies of the notice in our office available for any patient's request. Our notice must be posted in a prominent area where it is reasonable to expect any patient will be able to read. If there are any revisions to the notice, we must make it available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Following, we must give our revised notice to each new patient at the time of service and to any person requesting a notice and post the revised notice as aforementioned.

Our office must make a good faith effort to obtain written acknowledgement of receipt of this notice with each patient with whom we treat and provide this notice, except in an emergency situation. If we are unable to obtain the acknowledgement, we must document our efforts and the reason we did not obtain it. The acknowledgement or lack thereof should be filed in the patient's medical record.

Patient Last Name:_____ **Patient First Name:**_____

Minor Last Name: _____ **Minor First Name:** _____

_____ _____

_____ _____

Address:_____

Telephone No: _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this sheet. We look forward to seeing you again soon!

I, _____acknowledge that I have received the notice of privacy practices from James K. Margolis, Ph.D. or Meredith R. Margolis, Ph.D.

Signature:_____ **Date:**_____

Signature of Person Authorized to Consent for Patient: _____

Relationship to Patient: _____