PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy/am aware of the **Patient Bill of Rights**; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.

- I have received a copy/am aware of this office's **Notice of Privacy Practices**, including the **Private Health Information (PHI)** designated at the time of visit.

- I have received information on/am aware of the Infection Control measures utilized by this organization.

- I have received a copy/am aware of the **Practice Disclosure (about our Practice, including the Grievance process)** and am comfortable with that information. I also understand this practices position on **Do Not Resuscitate (DNR) and Living Wills** and that this practice does not honor these directives.

Signature of Patient/Representative_____Date_____

Above signature was not obtained because:

☐ Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures.

☐ Patient refused to sign.

☐ Patient refused forms.