ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / PATIENT RIGHTS & RESPONSIBILTIES / ADVANCE DIRECTIVE / OWNERSHIP DISCLOSURE / NOTICE OF NONDISCRIMINATION / FOREIGN LANGUAGE ASSISTANCE

I acknowledge that I have received a copy of the Notice of Privacy Practices from Eye Surgery Center of North Alabama (ESCNA).

I acknowledge that I have received a copy of the Patient Rights & Responsibilities, Advance Directive Policy, Ownership Disclosure, Notice of Nondiscrimination, and Foreign Language Assistance from ESCNA.

It is the policy of ESCNA to not honor advance directives, but a copy of your advance directive or the essence of it will be provided to any healthcare facility to which you would be transferred in the event that it becomes necessary.

ESCNA will disclose your personal information only in those situations necessary in order to provide you safe and effective treatment, to receive payment for the care you have received in our facility, and for other health care operations as deemed necessary.

I authorized the staff of ESCNA to leave messages on my home phone recorder, or with family or caregiver as deemed necessary.

I Give Permission for my protected health information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the family members and others.

❑ **Yes** ❑ **No** ❑ **Limited disclosure to persons listed below:**

Name(s): ____

Please Print Patient Name: ____

Signature: ____Date: _______________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Notice/Patient Rights and Responsibilities, but the acknowledgement could not be obtained because:

_______ Individual refused to sign.
_______ Communication barriers prohibited obtaining the acknowledgement receipt
_______ An emergency situation prevented us from obtaining acknowledgemen
_______ Other (Please Specify) ____