Notice of Privacy Practices Acknowledgment Form

Devoted MEDICAL GROUP

Full Name:

Insurance Plan:

Insurance Member ID:

I have received a copy of the Notice of Privacy Practices.

Signature: (Yours or your Authorized Representative's)

Date:

If signed by an Authorized Representative:

Printed Name:

Relationship to patient:

Witness:

Date:

This form must be retained for a period of at least six years in the appropriate record.

FOR INTERNAL USE ONLY

If the individual or an Authorized Representative with legal authority to make decisions on behalf of the individual did not sign the Notice of Privacy Practices Acknowledgement, staff must document when and how the notice was given to the individual and Authorized Representative, why the acknowledgment could not be obtained, and the efforts that were made to obtain it. (If the individual does have an Authorized Representative, the notice must be given to them as well and acknowledgment obtained from the Authorized Representative. If neither the individual nor the Authorized Representative signs, this form must be filled out. If either does, this form is not required.)

Notice of privacy practices given to individual on:

DATE:	☐ In-person meeting ☐ Mail ☐ Email ☐ Other:

FOR INTERNAL USE ONLY

Reasons individual or representative did not sign this form:

- ☐ Chose not to sign
- ☐ Other:
- ☐ Did not respond after more than **ONE** attempt
- ☐ Email receipt verification

Good Faith Efforts:

The following good faith efforts were made to obtain the individuals's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoke to and outcome of attempts) the efforts that were made to obtain the signatures. More than **ONE** attempt must have been made.

- ☐ In-person presentation(s)
- ☐ Telephone contact(s)
- ☐ Mailing(s)
- ☐ Email
- ☐ Other

Staff Signature:	
Printed Name:	
Title:	Date:

Please send your completed form to:

Mail
Devoted Medical Group
2801 SW 149th Avenue, Suite 100
Miramar, FL 33027

Fax
1-888-973-8821