NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Dr. Jamie Gottlieb

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices (NPP), containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change is NPP from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NPP.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Client Name (please print) _____

Relationship to Client _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgment on this NPP Acknowledgment, but I was unable to do so as documented below:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented me from obtaining acknowledgment

_____ Other (please specify) _____

Date _____ Initials _____