

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES
Heidi H. Wasch PhD**

I understand that under the HIPPA (Health Insurance Portability and Account and Ability Act of 1996), 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 health-care 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.

By signing below, I understand the Privacy Practices from Heidi H. Wasch PhD.

Patient Signature

Date

Witness Signature

Date

Documentation of Failure to Obtain Signed Acknowledgement

On _____, I, _____ employee of Heidi H. Wasch PhD presented this Acknowledgement of Receipt of Notice of Privacy Practices form to patient _____. The patient refused to provide a signature when requested.