ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

OWNERSHIP DISCLOSURE NOTICE

Please be advised that our physicians have an ownership interest in the Orthopaedic Hospital of Wisconsin. In the course of your diagnosis and/or treatment at our office, you may be referred for services at the Orthopaedic Hospital of Wisconsin. If you prefer that the services for which you are referred be provided at a different facility, please notify one of our staff members at, or as soon as possible after, the time of such referral so that alternative arrangements can be made.

_____ _____

Name of Patient | Signature of Patient/Personal Representative

_____ _____ _____ _____

Date Signed | Relationship to Patient if signed by Personal Representative

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OFFICE USE ONLY:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices provided to the individual. If written acknowledgement is NOT obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

☐ Refused ☐ Physically unable to sign ☐ Other_____

_____

_____

_____ _____/_____/_____

Employee Signature | Date