

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES
Midwest Fertility Specialists**

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 acknowledge that I have been offered/received a copy of Midwest Fertility Specialists Notice of Privacy Practice.

Patient Signature

Date

Witness Signature

Date

Documentation of Failure to Obtain Signed Acknowledgement

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The Patient refused to sign
- Communication barrier
- Emergency situation
- Other

Employee Signature

Date