Midwest Fertility Specialists

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I understand that under the HIPAA (Health Insurance Portability and Accountability 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

_____ _____
MFS 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