MAP
MERIDIAN ADVANCED PSYCHIATRY

# Acknowledgement of Receipt of Notice of Privacy Practices

## Please Read and Initial the Following

A. I have received a copy of Meridian Advanced Psychiatry's Notice of Privacy Practices. Initial_____

B. I agree and understand that other patients will be receiving medical care during my visit and may overhear information regarding my plan of care. Initial_____

C. I agree that a Registered Nurse or Medical Assistant or a nursing student or a medical assistant student may assist in my care. Initial_____

D. I consent to MAP representatives contacting me by telephone and or by leaving a message at the number provided. The MAP representative will identify themselves and the name of the practice, MAP. No Specific information regarding my treatment will be discussed or left via voicemail. Initial_____

E. I consent to MAP representatives contacting me via Text Message at the number provided. Standard text rates may apply. The MAP representative will identify themselves and the name of the practice, MAP. No Specific information regarding my treatment will be texted. Initial_____

F. By signing below, you understand your visit may be recorded and that the recording may be copied and used internally for training and educational purposes only by MAP. Initial_____

G. Initial_____

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| _____ | _____ | _____ |
|---|---|---|
| Patient and/or guardian Print Name | Patient and/or guardian Signature | Today's Date |

This Section is For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐Individual refused to sign

☐Communication barrier prohibited obtaining the acknowledgement

☐An emergency prohibited obtaining the acknowledgement

☐Other (please specify): _____

_____ _____

MAP Representative Print Name MAP Representative Signature

_____ _____

Patient's Account Code Today's Date