MOUNT PLEASANT MEDICAL ASSOCIATES

Notice of Privacy Practices Acknowledgement

I acknowledge that:

A copy of the Mount Pleasant Medical Associates Notice of Privacy Practices was made available to me at the location where I registered for and/or received health care services.

The *Notice of Privacy Practices* was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I know that I can ask for an additional copy of the *Notice of Privacy Practices* at any future date of service or upon request.

If I came in for health care services in an emergency treatment situation, I was able to view the *Notice of Privacy Practices* as soon as reasonably practicable after the emergency treatment situation.

_____
Printed name of patient

_____ _____
Signature of patient or patient's representative Date

_____
Relationship to patient (if other than patient)

Medical Records #: _____

[If the above signature is that of a patient's representative, complete the verification section below.]

MPMA has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____(description of authority to act, e.g. husband, wife, etc.), he/she is authorized to act on behalf of the patient.

Verification completed by:

_____ _____
Associate name and signature Date

To Be Completed By Mount Pleasant Medical Associates

If an acknowledgment is not obtained, indicate the reason why the acknowledgment was not obtained:

_____

_____

Individual delivering the Notice of Privacy Practices:_____ Date: _____